ORIGINAL PAPER

Planning and Implementing an Organizational Health Assessment in a Community Mental Health Setting

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Abstract

The workforce is the essential driver behind mental health service provision and the most valuable asset to any community mental health organization. To build and retain a stable and healthy workforce, systematic recruitment and retention strategies are needed. An organizational health assessment is a valuable tool in developing targeted organizational interventions to create a positive work environment and retain an engaged workforce. Starting in 2017, a large community mental health organization in Southern California implemented such an assessment to drive actionable steps to improve employee experience and decrease turnover. This case study describes the development and implementation of a low-cost organizational health assessment through five phases: development of the assessment, data collection, analysis, metrics and data visualization, and dissemination of findings and development of interventions. Key lessons learned include the importance of utilizing the findings and achieving staff and leadership buy-in.

Keywords Community mental health · Workforce · Measurement design · Mental health services · Evaluation and community research · Management and organizations

The community mental health (CMH) workforce is the most essential component of quality mental health service provision and the greatest asset to any CMH organization. With an estimated 51.5 million people in the United States with a mental illness (Substance Abuse & Mental Health Services Administration, 2020), a stable and healthy CMH workforce is critical to meeting mental health needs. A key reason for the continued lack of access to needed behavioral health services is the shortage of quality behavioral health workers (Covino, 2019). Factors that contribute to this shortage include lack of competitive wages and benefits, poor safety in the physical work environment, unmanageable workloads, limited administrative support and support from supervisors, job role ambiguity, lack of team cohesion, and exclusion from decision making (Stuart et al., 2009). In their report on the U.S. behavioral health workforce, Stuart and colleagues

(2009) found that systematic recruitment and retention strategies were required to retain workers.

The use of an annual organizational health assessment (OHA) can inform the development of organizational and managerial interventions that create a positive work environment, allow for continual monitoring of employee experience, and provide warning signs of turnover (Leiter & Maslach, 2010), thereby promoting staff retention. OHAs have been used widely in the corporate sector (Raya & Panneerselvam, 2013; Singh & Jha, 2018) and more recently in human service organizations. For example, in the child welfare sector, a field that shares similarities with the behavioral health field like low wages, high caseloads, and the challenging nature of clinical work (Strolin et al., 2006), OHAs have been used to determine why employees stay or leave their jobs, factors affecting service effectiveness, and employee attitudes (Glisson, 2007; Hemmelgarn et al., 2006; Potter et al., 2016). OHAs in child welfare and mental health organizations have typically assessed organizational culture (e.g., workload), climate (e.g., inclusion in the organization), and worker attitudes (e.g., job satisfaction; Potter et al., 2016). This information is then used to inform organization-wide interventions for organizational improvement (Potter et al., 2016).

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This case study details an annual low-cost OHA implemented in a CMH organization. It is undergirded by assumptions in the Hart and Cooper (2001) organizational health model. The fundamental assumptions of their organizational health model are that individual and organizational characteristics (e.g., positive or negative work experiences, organization climate) affect employee well-being (e.g., job satisfaction, job stress, burnout, morale) and that employee well-being subsequently affects organizational performance (e.g., turnover, productivity, employee performance). This paper describes the development and implementation of an OHA in a large behavioral health organization. The findings provide organizational leaders with practical tools and knowledge to implement an OHA to evaluate the needs of their employees, identify areas of improvement for employee well-being, implement data-informed organizational interventions, and promote employee retention.

Case Study

Background

This case study is based on the implementation of an annual OHA at a large nonprofit CMH agency in Southern California experiencing high staff turnover. The agency depends on its more than 500 employees to serve more than 8000 clients every year in its mental health, substance use, and outpatient suicide prevention services. Between 2012 and 2017, voluntary turnover rates in the agency ranged from 22 to 27%, with higher rates for the clinical staff (i.e., workers directly serving clients; 25 to 35%). These rates surpassed the turnover rates in all U.S. industries (19 to 25%) and the health care and social assistance sector (17 to 22%; Bureau of Labor Statistics, 2021). High turnover negatively affected staff morale, increased the workload burden for those who stayed, and challenged the agency's financial health. In 2017, agency leaders began systematically tracking staff turnover by location, work unit, and position. This led to the development and implementation of an OHA to better understand the root causes of turnover and develop interventions to decrease employee turnover, with a focus on decreasing high work pressure and subsequent job burnout and improving job satisfaction, engagement, and retention.

Phase 1: Developing an OHA

The first phase of the OHA included a targeted literature review and development of a survey based on current organizational health measures such as job satisfaction, work engagement, and intention to leave, which are used in various fields including organizational psychology and business management. Agency leaders initially explored hiring external consultants to assess the organizational factors contributing to organizational turnover. However, the consulting services were cost prohibitive and the consultant evaluation proposals were not grounded in current research. Alternatively, the agency's research and evaluation department conducted the OHA by designing a survey based on theory and the current literature.

Literature Review

The literature review focused on industrial and organizational psychology, human service organizations, and workforce management. The review suggested that organizational health factors, or the shared perception of the psychological impact of the work environment on individual employees, were important determinants of organizational outcomes such as turnover intentions (Glisson, 2000). The Job Demands-Resources Model (JD-R; Bakker & Demerouti, 2007) provided a theoretical framework to explain how the various organizational health factors were interrelated and led to negative work outcomes (e.g., intention to leave). The JD-R model assumes that job demands and resources affect employee health and well-being and if an imbalance exists (e.g., high demands and low resources), workers will experience poor health and well-being that leads to negative outcomes such as turnover or poor work performance (Schaufeli & Taris, 2014). The model is flexible in that it assumes that all jobs have unique demands (i.e., physical or psychological effort) and resources (i.e., aspects of the job that facilitate work or lead to personal development; Schaufeli & Taris, 2014). Guided by the JD-R model, we explored organizational health factors previously found to reflect job demands or resources in CMH organizations and other comparable organizational contexts (i.e., child welfare, health sector, nonprofit organizations). For example, previous research has shown that demands such as work overload (Halbesleben, 2010) and role ambiguity (Hakanen & Roodt, 2010) are negatively related to work engagement. Conversely, resources such as supervisor relationships (Mor Barak et al., 2009) and connection to mission (Kim & Lee, 2007) are related to job satisfaction in CMH settings. Based on the literature and the key assumptions of the JD-R model, we developed and tested a theoretical model of the relationships among organizational health factors predicting job satisfaction and intention to leave.

Survey Development

We identified and assessed the following 11 organizational health factors using established scales: (a) job satisfaction, (b) affective engagement, (c) team commitment, (d) connection to mission, (e) supervisor relationship, (f) communication satisfaction, (g) diversity climate, (h) role ambiguity,

(i) pressure to produce, (j) job burnout, and (k) intention to leave (for scale information, see Table 1). Based on the literature review and a path analysis, we conceptualized these factors into predictive, mediating, and outcome variables, as seen in Table 1.

The research and evaluation team and other key organizational personnel members assessed the face and convergent validity of the scales used (for a primer on best practices, see Boateng et al., 2018). Scales were modified where appropriate to minimize the survey length and reduce the cognitive burden on respondents. Scale modifications included removing redundant items and making scale response ranges consistent across measures. Items considered to reflect a core aspect of a construct were retained to limit threats to content validity. All scale response options were Likert-like responses ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The scale assessing connection to mission was the only measure developed internally for the OHA, to capture the overall sense that the organization is achieving its mission and that the respondent's work is a contributing factor. This four-item scale was developed by reviewing previously established scales on organizational commitment (Allen & Meyer, 1990) and vision (Testa et al., 1998).

Demographic and open-ended questions were included in the OHA. The open-ended questions included: "What aspect of your job makes you most satisfied?"; "What changes during the past year have improved your work experience at [Organization]?"; and "What additional changes could be made to improve your work experience at [Organization]?" The final OHA consisted of 65 questions measuring 11 organizational health factors, three open-ended questions, and three demographic questions (e.g., job tenure, position, and work unit). The expected time to complete the survey was 15–25 min.

Phase 2: Data Collection

The survey was administered annually in the fall to all staff members using the SurveyMonkey online survey platform from 2017 to 2021. The annual OHA data collection allowed tracking of trends in the organization and assessment process. To encourage participation, staff members were informed that their responses would remain anonymous and survey findings would only be reported in aggregate. Importantly, the survey was supported and promoted by work unit leaders (e.g., supervisors and managers). The data collection

Table 1 Organizational health factors and intention to leave scale

Variable	Sample item	Items	Cronbach's alpha	Cutoff value[d]
Predictor variables				
Team commitment[a] (Mowday et al., 1979)	This team really inspires the very best in me in the way of job performance	6	.76	3.55
Connection to mission[b]	My personal values align with the mission and goals of the agency	4	.82	3.63
Supervisor relationship[a] (Scandura & Graen, 1984)	I would support my supervisor's decisions even in his or her absence	5	.81	3.70
Communication satisfaction[a] (Downs & Hazen, 1977)	I receive information about agency policies and goals	7	.82	3.20
Role ambiguity[a,c] (Rizzo et al., 1970)	I have clear planned goals and objectives for my job	5	.88	3.70
Diversity climate (Sammartino & Nicholas, 2001)	I feel positive about diversity in this workplace	11	.93	3.50
Pressure to produce[e] (Patterson et al., 2005)	People here are under pressure to meet targets	5	.85	3.45
Mediating variables				
Job satisfaction (Quinn & Staines, 1979)	All in all, I am satisfied with my job	4	.91	3.63
Affective engagement[a] (Soane et al., 2012)	I am enthusiastic in my work	3	.83	3.70
Burnout[a,e] (Kristensen et al., 2005)	I am exhausted in the morning at the thought of another day at work	5	.90	2.90
Outcome variable				
Intent to leave (Abrams et al., 1998)	In the next few years, I intend to leave this organization	4	.91	–

[a]The scale used in the OHA was adapted from original scale. [b]Connection to Mission scale was internally developed. [c]The scale direction for role ambiguity has higher scores representing more role clarity and lower scores more ambiguity; therefore, the scale was presented as role clarity. [d]Cut-off value represents the threshold that determines positive or negative organizational health. Factor scores below the cut-off represent scores indicative of negative organizational health for all factors except pressure to produce and burnout. [e]Higher scores for pressure to produce and burnout represent greater pressure and burnout, respectively. Therefore, scores above the cutoff represent scores indicative of a climate promoting intention to leave

period ranged from 3 to 4 weeks and included reminder emails to all staff members and work units. In 2017, the survey was distributed to 503 staff members (341 clinical and 162 nonclinical), and the response rate was 77% (62% for clinical and 84% for nonclinical). In subsequent years, the response rate for the surveys ranged from 73 to 96%.

Phase 3: Analysis

A rigorous analysis was conducted so the findings would be useful for decision making and developing interventions. The analyses had two areas of focus. The first involved a path analysis to model the relationship of organizational health factors and turnover intentions. The second analysis included developing useful profiles based on the assessed factors and qualitative data to inform the development of interventions at the unit and organizational level to target and reduce turnover. Data screening and analysis for the quantitative data were completed in the statistical program R.

Data Screening

Prior to the analysis, data were screened for completeness, accuracy, and quality. Missing data for the organizational health factor items were examined using Little's (1988) missing completely at random test and determined to be minimal (<5%) and missing completely at random. Participant scale averages were imputed for each scale with one missing item, whereas listwise deletion was done for any scale with more than one missing item. Organizational health factor scores for each respondent were then calculated as the average scale response. Score distributions were examined, and data was screened for outliers. Cases with extremely low response times, zero-variance responses, and impossible demographic combinations were excluded from the analysis.

Scale Reliability

As previously mentioned, all scales except for the connection to mission scale were taken from validated measures (see Table 1). Cronbach's alpha, inter-item and corrected item-total correlations were calculated to test the reliability of the scales used. All scales had a Cronbach's alpha ranging from 0.76 to 0.91, indicating good scale reliability. Average inter-item correlations were between 0.20 and 0.40, meeting the standard for homogeneity between items with sufficient unique variance (Cohen & Swerdlik, 2005). Corrected item-total correlations exceeded 0.20, indicating a shared relationship between the items and the construct (Lord & Novik, 1968).

Path Model Analysis

To better understand the interrelations between the OHA factors and their relationship to turnover intentions, a path model analysis was conducted. A path model, a form of structural equation modeling, allows for the simultaneous testing of various causal interrelationships between variables (Land, 1969). We developed and tested a path model informed by the literature on turnover in the CMH context and the JD-R model. Path modeling was selected because of its ability to test various organizational health factors simultaneously, which more effectively captures the interplay between the factors examined. For example, engagement was modeled as a mediator of organizational health factors and turnover intentions (see Pasquarella et al., 2022). We tested each factor's relationship to intention to leave, as mediated by engagement, job burnout, and job satisfaction (see Table 1). This allowed us to understand the relative impact of each organizational health factor on turnover intentions, how they were related, and how addressing one may affect the other. For example, we discovered that team commitment was a strong predictor of engagement and job satisfaction and had a direct impact on intention to leave. This suggested that for our agency, building team commitment could have wide-ranging benefits for employee experiences. Additionally, we found that role clarity did not affect job satisfaction but was important to employee engagement and related to lower levels of perceived productivity pressure, suggesting that improving role clarity could lead to a more engaged staff and lower pressure to produce. Although the data were cross-sectional and causality could not be tested, compared to a single multiple regression model, the path model offered greater insight into how the organizational health factors were related. Finally, the results of the path model provided support for the OHA factors as early warning signs of turnover.

Qualitative Analysis of Open-Ended Questions

The qualitative survey items provided insight into organizational health factors not captured in the quantitative portion of the assessment. Two coders independently coded the qualitative responses, compared and verified codes, and collaboratively established emergent themes (for a primer on qualitative analysis, see Vaismoradi et al., 2016). The qualitative comments were used to triangulate the findings from the quantitative analysis and current literature. Moreover, the themes helped fill gaps unmeasured by the quantitative analysis and provide organization-specific insights into employee experiences.

Phase 4: Metrics and Data Visualization

Metrics should be straightforward, standardized, accurate, precise, robust, and direct to convey the assessment results effectively (Anderson, 2015). With careful metric selection and using design principles for data visualization detailed by Evergreen and Metzner (2013), we developed two-page profiles with the following metrics: voluntary turnover rate from the previous year, percentage of staff members indicating job satisfaction and intention to leave, average scores on each scale, high scoring proportion trends over time, and thematic results from the qualitative analysis. The structure and format of the profiles were standardized so the results could easily be presented by subgroups (e.g., work unit, site location, and positions) and compared across subgroups. The actual OHA profile for the agency is presented in Fig. 1 as an example of types of profiles created. The name of the agency has been withheld for confidentiality. As seen in Fig. 1, beginning at the top of the document, voluntary turnover rates from the previous year, percentage of staff indicating job satisfaction and intention to leave, average scores on each of the scales with cut off scores, high scoring proportion trends over time, and thematic results from qualitative analysis were presented. Color schemes were used to convey important information, with shades of green used to convey positive organizational health factors such as being satisfied in the job and intentions to stay in the organization. In contrast, red was used to underscore negative organizational health factors such as being unsatisfied in the job and intentions to leave the organization. The following sections detail how the metrics were created.

Creating Organizational Health Factor Scores

Although average factor scores are informative, understanding how to interpret averages to make decisions about organizational interventions can be challenging. To aid in interpreting the average organizational health factor scores, we developed cutoff scores, or thresholds, for each factor. These cutoff scores were based on predictive probabilities instead of a priori scale characteristics or organization averages. They differentiated respondents who were or were not likely to intend to leave the organization in the next few years. We utilized receiver operating characteristic curve analysis and evaluated the area under the curve to determine cutoff values that maximized sensitivity and specificity (for detailed instructions, see Metz, 1978).

Categorizing Organizational Health Factor Scores

To make scale scores into meaningful and understandable metrics, factor scores were grouped into three categories: low (1.0–2.5), moderate (2.6–3.4), and high (3.5–5.0).

Although this intuitively made sense given the scale anchors and range, scale score distributions were also examined, and respondents largely fell into these categories evenly. Moreover, for many scales, 3 represented the mean, with 0.5 being half a standard deviation. Profiles displayed each category grouping with proportions of staff members regarding job satisfaction and intention to leave.

Proportions of "high scorers"—those who scored 3.5 or higher—were then created for each factor and compared between programs and site locations (i.e., across clinic sites). This yielded a simplified and understandable way for staff members to compare trends over time, conceptualize their program's health, and identify factors where the agency was doing well and areas in need of improvement. The high score proportions for each year were added to the profile to demonstrate trends. Having factor scores with cutoffs and high score proportions allowed the profiles to display absolute and relative metrics.
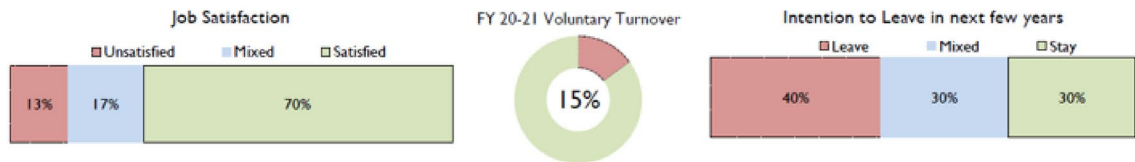
Phase 5: Dissemination of Findings and Developing Interventions

A primary purpose of the OHA was to gather key quantitative and qualitative information about drivers of staff turnover intentions, allowing us to develop tailored, actionable steps to improve the organizational health and employee experience and in turn, decrease employee turnover. The keys to utilizing the findings from the OHA are to focus on organizational interventions (i.e., changes affecting the entire organization) and managerial interventions (i.e., changing management processes to effect change in employees' experiences), encourage participation and collaboration across job levels, establish an ongoing process, and share information about findings and action planning openly across the agency (Leiter & Maslach, 2010).
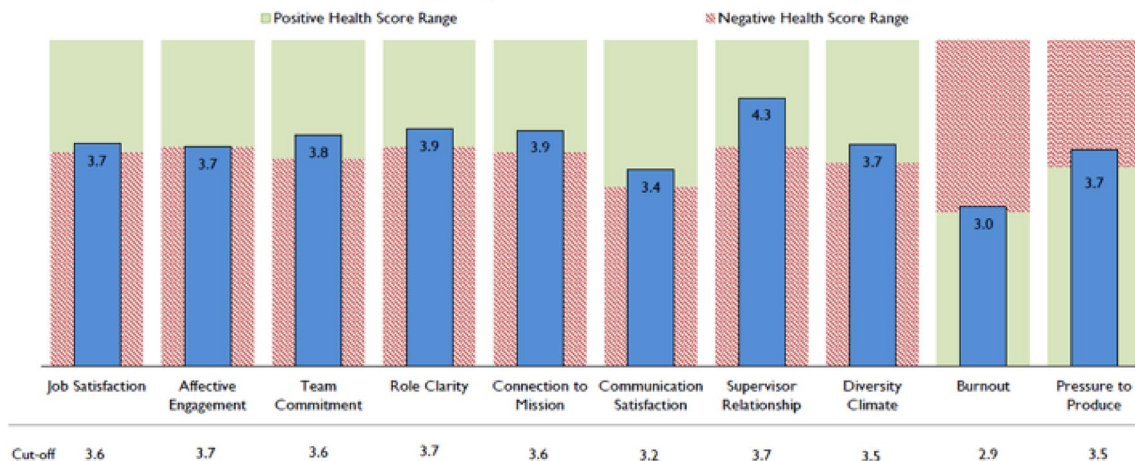
Organizational-Level Interventions

Recognizing that an organization is a set of interrelated work units, interventions at both the organizational and work unit levels were developed. At the organizational level, executive management reviewed the key findings (via the path model results and profiles) and developed initiatives that affect the organization as a whole. Our quantitative findings showed that decreases in job satisfaction, engagement, team commitment, connection to mission, supervisor relationship, communication satisfaction, diversity climate, and role clarity were each associated with significant increases in intention to leave. Conversely, increases in pressure to produce and burnout were each significantly associated with increases in intention to leave. These findings served as the basis for developing key tailored interventions at both the organizational and work unit levels. Sample interventions include

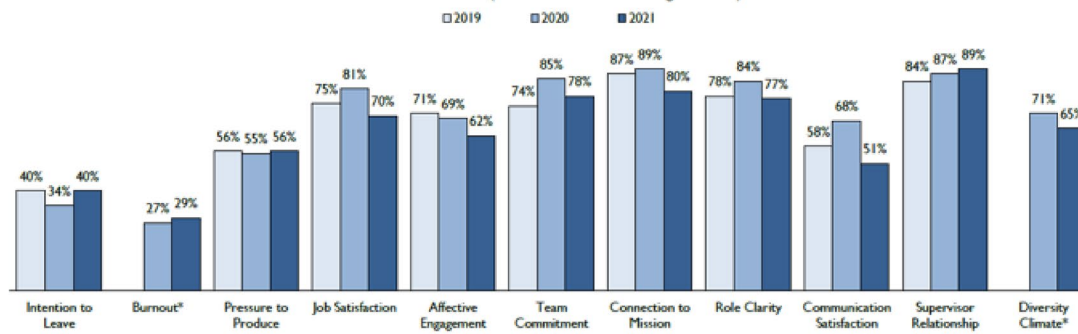# [AGENCY] ORGANIZATIONAL HEALTH PROFILE

Job Satisfaction

■ Unsatisfied ■ Mixed □ Satisfied

| 13% | 17% | 70% |

FY 20-21 Voluntary Turnover

15%

Intention to Leave in next few years

■ Leave ■ Mixed □ Stay

| 40% | 30% | 30% |

Average Organizational Factor Scores for All Staff

□ Positive Health Score Range ▨ Negative Health Score Range

	Job Satisfaction	Affective Engagement	Team Commitment	Role Clarity	Connection to Mission	Communication Satisfaction	Supervisor Relationship	Diversity Climate	Burnout	Pressure to Produce
Score	3.7	3.7	3.8	3.9	3.9	3.4	4.3	3.7	3.0	3.7
Cut-off	3.6	3.7	3.6	3.7	3.6	3.2	3.7	3.5	2.9	3.5

Note: Values represent the average score for each organizational factor. Higher and lower scores represent more and less of the factor, respectively. Burnout and Pressure to produce are the only factors where higher values are associated with negative health. Cut-off value is the point that separates positive and negative health score ranges.

All Staff Organizational Health Comparison from 2019 to 2021
(Percent of Staff with High Scores)

□ 2019 ■ 2020 ■ 2021

	Intention to Leave	Burnout*	Pressure to Produce	Job Satisfaction	Affective Engagement	Team Commitment	Connection to Mission	Role Clarity	Communication Satisfaction	Supervisor Relationship	Diversity Climate*
2019	40%		56%	75%	71%	74%	87%	78%	58%	84%	
2020	34%	27%	55%	81%	69%	85%	89%	84%	68%	87%	71%
2021	40%	29%	56%	70%	62%	78%	80%	77%	51%	89%	65%

Note: High scores are values 3.5 or higher on a scale from 1 to 5.
*Burnout and Diversity Climate are new factors added for 2020.

Staff Satisfaction

The top three factors driving employee satisfaction were:

43% Providing Client Care

41% Helping Communities in Need
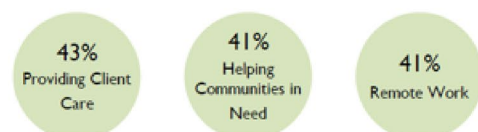
41% Remote Work

In addition to the factors above, staff were satisfied with flexible scheduling and their connection to/support from supervisors and coworkers. They saw remote work, better technology, more team building, more staff appreciation/DEI initiatives, addition of mental health sick time, faster hiring, and remote trainings as major improvements since last year.

Staff Concerns

The three main drivers of staff intention to leave the agency were

53% Compensation Dissatisfaction

33% Burnout

21% Lack of Career Advancement
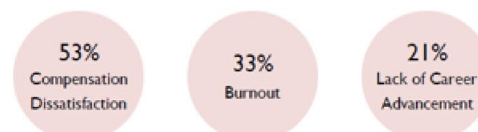
In addition to the factors above, staff intended to leave due to lack of transparency/action from leadership, unrealistic expectations, understaffing, and feeling undervalued/unappreciated. Staff wanted to see higher pay, more focus on retaining employees, continued remote work and schedule flexibility, more realistic expectations, more action on DEI, and more focus on staff mental health.

◄**Fig. 1** Agency's organizational health profile sample. *Note* The figure represents a two-page agency OHA profile as an example of how the information gathered was presented to the agency staff. The information is real agency data, but the name of the agency has been withheld. Voluntary turnover rates from the previous year, percentage of the staff indicating job satisfaction and intention to leave, average scores on each scale with cutoff scores, high scoring proportion trends over time, and thematic results from qualitative analysis are presented. The Role Ambiguity scale was presented to the staff as role clarity to make it easier to understand the data. Higher scores on this scale represent more role clarity and lower scores reflect more role ambiguity

recruitment of a diversity, equity, and inclusion director; implementation of a more seamless electronic health record system to reduce the administrative burden for the clinical staff; expanded professional development opportunities to further staff engagement; and redefined supervisor roles to improve job clarity.

The qualitative findings both corroborated the quantitative findings and provided additional insight into staff work experiences. For example, the qualitative findings provided more detailed information on the staff's communication dissatisfaction and supervisor relations, which helped identify that the breakdown in communication and support had occurred at the middle management level. This ultimately led to management training directed toward middle managers to improve their communication and managerial skills.

Managerial Interventions

Managerial interventions were created at the work unit level. A process was developed to guide mid-level managers in interpreting and using the assessment findings to implement quality improvement (QI) plans for their unit (see Fig. 2). The assessment findings were presented at a large managerial meeting for clinical and nonclinical managers and supervisors. Results were presented and profiles distributed to managers and supervisors to facilitate the development of QI plans. Each manager received three profiles: their location-level work unit, the division of their work unit (e.g., adult outpatient division), and the overall agency. This allowed the managers to compare the organizational health of their work unit relative to other work units in the division and agency, providing a point of comparison for their unit's strengths and areas needing improvement. During this meeting, staff members were grouped by work units to examine collectively how their profile looked in comparison to the agency. To facilitate the interpretation of their results and the development of a QI plan, managers received a worksheet outlining the process and guiding questions to consider (see Table 2). The questions guided managers in identifying their staff's level of satisfaction, intent to leave, and other organizational health factors. Unit managers developed a proposal

for improvements, which was presented to the vice president of clinical operations for approval and implementation.

Then, unit managers engaged their staff members in the intervention development process, collaborating with them to modify the draft action plan. Finally, unit managers shared their experience and lessons learned (e.g., what did and did not work) during a follow-up managers' meeting. These meetings helped ensure managers were accountable in using the assessment findings and implementing changes at the work unit level. The meetings also provided an opportunity for shared learning, whereby unit managers adopted successful strategies used by other unit managers. For example, several work units found that burnout and pressure to produce were especially high among their staffs and decided to focus on decreasing these concerning OHA factors. They implemented staff wellness rooms, a private area where staff members can go to when they are feeling stressed or overwhelmed or need to decompress after mental health sessions with clients. These wellness rooms were designed to alleviate some of the burnout or vicarious trauma staff members may have experienced. In addition to wellness rooms, the agency promoted its Employee Assistance Program more actively and encouraged staff members to utilize its mental health and other services. Overall, by implementing this dissemination strategy and involving staff members at all levels in the QI projects, we achieved meaningful changes at the work unit and organizational levels.

Effectiveness of Interventions

The next step of an OHA is to evaluate the effectiveness of the interventions implemented, but there are several challenges in undertaking such evaluations. First, the OHA data were collected anonymously, which did not allow for longitudinal data analysis. This decision was made because of the staff's concerns that survey responses would be identified and honest responses would lead to negative consequences. Many staff members hesitated to complete the assessment because of this fear, and a decision was made to anonymize the survey to address their concerns and ensure a high response rate. Also, organizational, environmental, social, and economic factors could have changed year to year and obfuscated the ability to discern causal relationships. Last, work units operate in a larger organizational context, and variability among them can confound overall change (Leiter & Maslach, 2010).

Despite these challenges, some encouraging trends and select work unit successes provide preliminary evidence of the effectiveness of the OHA. Overall, turnover rates in the organization decreased after the implementation of various strategies informed by the OHA. As mentioned, at the start of the OHA, voluntary turnover rates (from 2012 to 2017) ranged from 22 to 27% and exceeded all other industry and
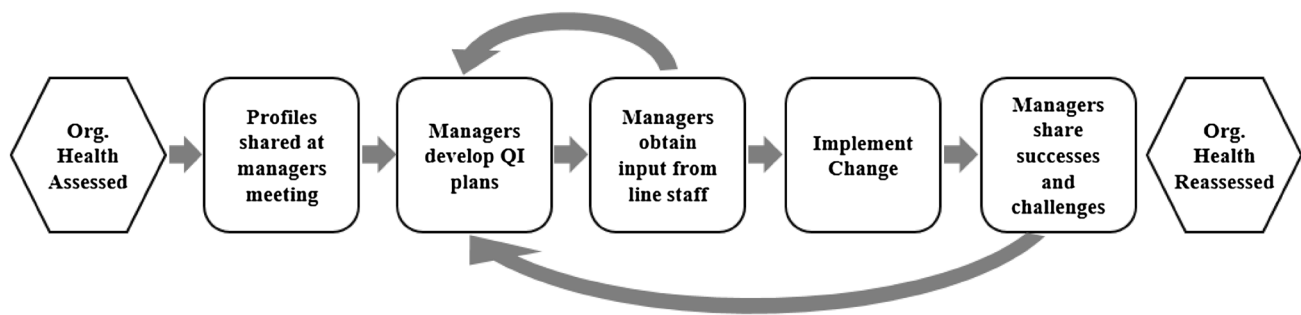
Fig. 2 Using survey results: developing quality improvement (QI) plans

Table 2 Guiding questions for a quality improvement plan based on survey findings

Guiding questions
How does your program compare on intent to leave relative to all clinical operations? To your division?
How does your program compare on job satisfaction? To your division?
How does your program compare on each of the organizational health factor scores? Relative to the cutoff scores?
What are (relative) areas for improvement?
What hypotheses do you have on your program's trends (root-cause analysis)?
What will be your specific program goal to improve job satisfaction?
What strategies can you put in place to meet your goal?
What do you feel are the best ways to roll this out to staff?

health care and social assistance sector turnover rates. Subsequent to implementation of the OHA and interventions in 2017, the turnover rates dropped steadily from 22 to 15% (in 2020 and 2021). As our agency turnover rates steadily decreased, the turnover rates for all industries and health care and social assistance sectors continued to rise (26 to 29% and 22 to 27% over time, respectively; Bureau of Labor Statistics, 2021). Moreover, qualitative feedback from staff members indicated that they felt more heard and appreciated and benefited from organizational changes, specifically those related to implementation of a new electronic health record system to reduce administrative burdens and increased professional development opportunities. At the work unit level, one large outpatient clinic with relatively high turnover (26%) and high intent to leave (33%) identified team commitment as an area of focus and implemented interventions to build stronger team cohesion. During the subsequent year, although its turnover rate (25%) only decreased slightly, staff intention to leave dropped from 30 to 20%, an early indication that turnover may decrease in subsequent years. Moreover, team commitment improved as staff members feeling highly connected to the team increased from 71 to 100%.

Given the success of the interventions from the initial OHA, the agency continued to conduct OHAs to assess the organizational environment and employee experiences, obtain direct systematic feedback from employees on changes in the organization, and assess the impact of new initiatives intended to target organizational health and turnover. As staff members saw that the assessment results were being used to make organizational and work unit improvements, they began to see it as a powerful avenue for their collective voices to be heard. Further, the transparent sharing of the assessment results and allowing staff members to have a direct hand in developing the action plans created a sense of buy-in and trust. This motivated them to participate in subsequent assessments, leading to higher response rates over time.

Conclusion

The assessment served as an effective tool to address staff turnover and increase retention in the organization, and agency leaders learned many lessons through the development and use of the OHA. One key to successfully implementing an OHA is to utilize assessment results extensively and broadly via making results accessible to all organizational members and ensuring the results lead to follow-up action plans. Many organizations conduct brief surveys, but the results are not shared widely or tied to specific action plans (Leiter & Maslach, 2010). Developing and implementing an OHA with specific utilization plans allows staff members to see that their voices are being heard by the leaders in the organization and that

changes are being made based on their feedback. Other prerequisites are needed for a successful OHA implementation. The organization's top leadership needs to support the OHA process, clearly communicate the value of the assessment, be committed to the anonymity of the individual responses, and actively utilize the assessment results for improvement. To obtain buy-in from staff members, they must be assured at the onset of the assessment that their responses are anonymous and that findings will only be presented in aggregate form. Efforts should be made to limit the collection of identifying information, and data must be carefully de-identified before results are presented. As employees witness that there are no negative consequences for participation in the OHA, their trust in the process will improve from year to year. Also, managers need to take ownership of their work unit results and have a safe place to reflect on the results. Self-reflection on their role as a leader should be encouraged and praised without being punitive. Last, it is recommended that the OHA be completed over multiple years, at the same time of the year, to examine trends over time and minimize seasonal effects on results. Conducting the assessment over multiple years allows the leadership to examine the impact of initiatives from previous years and observe significant changes or trends that affect the organization. Furthermore, it provides leadership with warning signs or early predictors of disengagement and turnover (Leiter & Maslasch, 2010).

We recognize some organizations may not have the resources to conduct an OHA at the scale presented here, which includes the development of a comprehensive survey, data collection, use of advanced statistical analyses, and detailed reporting. Even with limited resources, any organization can conduct an OHA on a smaller scale to gauge the current state of organizational health and employee work experiences and use the findings to develop action plans for improvement. Although advanced statistical analysis of data can provide more information about how different factors interact and predict job satisfaction and turnover intention, descriptive analysis of the data collected is sufficient and can provide useful information about the state of the organization. Gathering OHA data can provide enough information to engage the staff and managers in QI plans and help build a data-driven organizational culture. In conclusion, regular assessment of organizational health can serve as an avenue for employees to voice their needs and for organizational leaders to respond in meaningful ways that encourage employees to remain engaged in their work and stay in the organization.

Declarations

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