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Translating Provider and Staff Engagement Results to Actionable Planning and Outcomes

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Abstract

Staff and provider engagement leads to better quality and experience of care and less turnover and burnout. In this program, we describe an approach to better understand underlying factors that lead to low staff and provider engagement and address such factors by creating actionable plans that drive improved engagement measures. Focus groups were conducted with staff, advance practice providers, and faculty to better understand low scored areas in an annual third-party engagement survey. Focus group results were analyzed, and thematic action plans were then developed by a leadership team. These plans and the status of addressing the identified issues were published and disseminated back to all staff and providers using a “stoplight report.” The leadership team met every 2 to 4 weeks until all issues were addressed and communicated back to the department. The subsequent year’s engagement scores statistically increased across all engagement score domains for both staff and faculty. We conclude that using a qualitative approach to understanding low-scored engagement domains will allow a deeper and authentic understanding of the root factors that drive low engagement scores. This approach allows teams to develop responsive action plans, resulting in higher engagement scores, which will eventually lead to better service and care to patients.

Keywords

employee engagement, clinician–patient relationship, communication, organizational culture, organizational communication

Introduction

In response to patients being more active as consumers of their health care, the market has driven organizations and providers to develop responsive strategies in the areas of patient experience and quality (1). One upstream organizational factor that affects patients’ experience and their quality of care is provider and staff engagement within organizations (2,3). A 2007 landmark white paper by the Institute for Healthcare Improvement set out a framework that lays out the necessary steps to engage medical staff to drive quality (4). Studies have demonstrated that an engaged workforce delivers a better experience and quality of care to their clients and improves safety (5–10). This results from an involved team of staff and physicians that have codeveloped and adopted a common set of beliefs and work values.

“Engagement” among providers and clinical staff is often considered the antithesis to burnout. Studies have shown that engaged teams result in lower rates of burnout and improved retention (8,9,11–14). Systems research has found that a higher level of physician engagement is correlated with higher job performance, decreased variations in care, and better revenues (15). In fact, one study demonstrated that

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provider engagement mediated the effectiveness of a hospital practice improvement module on quality outcomes (16).

Health-care organizations commonly utilize validated assessments to measure, and respond to, their company's physician and staff level of engagement. Yet, quantitative engagement results alone are limited in their ability to define and facilitate understanding of the root factors that potentially drive low morale and loss of engagement; they also have limited ability to identify areas of development. Hence, in order to develop responsive changes or interventions, there is a need to investigate the factors identified on these quantitative surveys.

The purpose of this article is to share how a large primary care department in an academic medical center utilized the FY2017 engagement survey results, administered by a third party, to develop action plans and accountability tools by conducting qualitative assessments of physicians and staff.

Methods

The Department of Family and Community Medicine (DFCM) at the University of Kentucky (UK) College of Medicine developed and deployed an innovative model to address annual physician and staff engagement results using a step-wise approach that involved telephonic and face-to-face interactions with physicians and staff during nonclinical hours. The approach, as detailed below, extended invitations to all staff and physicians. The UK Office of Research Integrity deemed this departmental improvement methodology assessment as exempt status for the Protection of Human Subjects.

Engagement Survey

The engagement survey is a confidential, validated 60-question assessment that scores staff and physician overall engagement, and other subdomains including staff, organization, leadership, and department (physician only survey). Fifteen questions are designated as "Power items" that calculate a unit's Tier status, 1 (highest) to 3 (lowest), according to published survey standards (17). Additional items include 6 questions to derive an "Engagement Indicator Score" with percentile rankings, and 6 other questions that comprise an "Action Planning Readiness" score to assess a unit's readiness to change. A third-party vendor for UK HealthCare conducts the web-based annual engagement survey during the spring of each year. The 2017 and 2018 DFCM response rates were 67% and 76%, respectively.

Approach

Our department received its engagement results in late spring 2017 and presented them to physicians and staff. Afterward, 3 faculty physician members independently reviewed the annual results to identify low-scoring survey items they considered actionable at the department level. For example, while salary and pay are important factors, the

department has limited ability to impact such factors as they are set at the university level. Out of the 60 questions, 40 were deemed to be potentially influenced or impacted at the departmental level and 17 items were deemed to be low-scoring items. Each reviewer grouped their identified items into common themes that would inform the development of an interview guide for focus groups.

An e-mail invitation to 148 staff and providers was sent to request participation in focus groups or telephonic interviews at a time of their convenience during lunch or breakfast hours, in which food was served. In order to ensure that there were no concerns of confidentiality, coercion, or potential power dynamics, an external trained facilitator who was not affiliated with the department conducted the focus groups so that open and honest information could be garnered. After introductions, the facilitator discussed general rules about the session and initiated conversation with open-ended questions using the developed guide. The same guide was used during each focus group meeting or interview as a tactic to delve deep into the underlying factors that may have resulted in the low-scored engagement items. No repeated interviews were conducted. The focus groups and interviews were audio recorded and were also accompanied with field notes to assess for any nonverbal cues. Three staff focus groups, 1 physician focus group, and 7 telephonic interviews with advanced practice providers (APPs) were conducted, for a total of 52 participants.

Analysis

Focus group analyses. All focus group recordings were transcribed and 2 trained external evaluators independently reviewed the transcripts in detail. The content was analyzed and categorized into a deidentified report. Reviewers had repeated discussions about the interpretations of the data that resulted in several iterations of the final report, enhancing the rigor of the process. No qualitative data analysis software was used.

Engagement surveys. We assessed the impact of our approach by comparing FY2017 engagement results to FY2018 results. A statistically significant change was defined as a change of ≥ 0.11 for provider results and ≥ 0.03 for staff results in any domain, as specified by the third party survey administrator.

Results

Spotlight Report

The thematic analyses by the 3 physicians from the engagement survey item responses were collated and a comprehensive thematic guide was developed by consensus during meetings with the physician reviewers. The analysis of the engagement results demonstrated a strong concordance among the 3 reviewers. The themes that arose for both staff and physicians as areas of opportunity included communication, ability to give input, need to be respected, a sense of trust/safety, a positive environment, and responsiveness

Table 1. Focus Group Guiding Questions.

Domain	Questions
Communication	What are meaningful ways that the clinic and department leadership can communicate with you so it can positively impact your everyday work life? What has been a problem in the past and are there things that are occurring now that you like?
Input/engagement	What are your ideas to improve communication? In what ways can the department and/or clinic make you feel engaged and that you are given an opportunity to provide input? Why do you think some in the department report that they have not been able to give input? And what are some positive things you are seeing that makes you feel engaged? Do you have suggestions on how we can improve this?
Valued/safe	What are areas or situations that you feel that it is unsafe to express your opinions or thoughts? What are some ideas that you can recommend to the department and clinic leadership so you and colleagues can feel valued and respected?

of administration. The guide was then presented to DFCM staff and physicians for further discussion, refinement, and final consensus. This resulted in 3 thematic domains and relevant focus group/interview guiding questions, as shown in Table 1.

A leadership team comprised of the departmental chair, medical directors, clinic managers, quality leads, and the ambulatory operations director met to develop a “stoplight report” that itemized action topics identified from the focus groups and interviews. A leader was assigned to each action topic to address and follow-through on the issue and report back to the group in a team meeting, which occurred every 2 to 4 weeks. Any action topic that was in the process of being addressed remained in “yellow” status until completed, at which point it moved to “green” status. Topics that were not approved or actionable were moved to “red” status. A partial sample of a Stoplight report is shown in Figure 1. Every time a stoplight report was updated, it was disseminated to all DFCM physician and staff by e-mail and posted on academic and clinic information boards. The team continued to meet until all items were moved into either “green” or “red” status. By late spring of 2018, of the 36 total action items, 30 items were moved to “green” status (complete) and 6 items were moved to “red” status (unable to accommodate).

Engagement Survey Results

After implementing our described approach in 2017, we assessed its impact by comparing it to the 2018 engagement results.

Physicians. There were 38 physician respondents with statistically significant increases across all 5 physician scores and domains (Figure 2A). There was a 0.17 increase in the mean for the engagement score, 0.27 increase in the alignment score, 0.23 increase in the staff domain score, 0.16 increase in the organization domain score, 0.25 increase in the leadership domain score, and a 0.43 increase in the department domain score.

Staff. There were 36 staff responses with statistically significant increases across all 4 staff scores and domains (Figure 2B). There was a 0.16 increase in the overall engagement score, 0.15 increase in the organization domain score, 0.09 increase in the manager domain score, and a 0.04 increase in the employee domain score.

Discussion

Assuring the involvement of those who you intend to positively influence is critical to developing actionable plans related to annual engagement results. As health care is more driven toward quality outcomes, it is imperative to maintain an engaged team-based workforce. We sought to be responsive to the needs and concerns of all employees, and make intentional efforts to be transparent on the status of action items (2–5,7–10). Our positive results were during a time of tremendous change in our health-care system. Yet, we were able to make a statistically significant impact through our efforts in listening and taking action where, informed by our physicians and staff, it mattered most. Using our innovative model, other departments and organizations may be able to conduct similar efforts to better understand the factors that drive low engagement, and develop actionable plans that can be deployed to make meaningful changes. Our efforts around the 3 main thematic areas that we identified (ie, communication, input/engagement, and valued/safe) are further discussed below to serve as examples of the action items that were addressed in the stoplight report.

Communication

Staff and physicians felt communication was central to their engagement. The focus groups and interviews allowed us to better understand that being abreast of activities, upcoming changes, and general news impacting the department was important to feelings of engagement. Overwhelmingly, e-mail was the preferred mode of communication. Responsive to this feedback, we developed a “Chit Chat” electronic newsletter that highlights important achievements, honored birthdays and work anniversaries, and informs the team on the progress of departmental activities.

There was a sense that our large department resulted in academic and clinical silos. In response, leaders now tour and conduct introductions of new hires to both academic and clinical team members. This aligns with other studies that have found leadership behavior impacts team engagement and even lowers burnout (18).

A directory with employee names, job positions, and pictures was developed and disseminated. Moreover, to ensure a

Department/Unit/Clinic: Family & Community Medicine		Date: March 6, 2018
GREEN/COMPLETE	YELLOW/WORK IN PROGRESS	RED/CAN'T COMPLETE AT THIS TIME AND HERE'S WHY
Email is the best way to communicate - Keep doing it!	Residents want to be in clinic-address the inefficiencies, stress and long hours -Dr. G has planned meetings with Dr. K and residents to discuss innovative strategies to improve their clinic experiences.. (DUE: Ongoing; Leads: Multiple)	Quarterly Lunches - Due to significant budget cuts we are unable to allocate funds to this activity. We will always seek opportunities to introduce this excellent idea
Staff do not know peers or other employees in the department - We developed a directory of names, roles, locations, and photos of all providers and staff; We will place on SharePoint and email a pdf to everyone.		Increase raises and bonuses – While we always look for these opportunities based on merit, controlling factors are set outside of the department
Patients talk to a person when they call Access center meets the needs of providers and patients - Workgroup initiative has developed a new tool for scheduling that will reduce errors. Recent reports showing very low wait times when patients call in. This is now active as of May 10, 2018.		Reimburse staff for uniforms or have payroll deduction Allow staff to wear colored or themed scrubs around holidays -There is Standard Dress Policies that limit our opportunity to meet these requests. These expenses are tax deductible and we encourage staff to deduct these expenses if applicable. (DUE: Now; Leads: KB/JA)

Figure 1. Sample spotlight report.

safe and anonymous opportunity to share feedback, we placed suggestion boxes in academic and clinical workspaces across our 4 locations. There was also an interest in enhanced communication regarding the financial and operational performance of the department. Hence, we implemented quarterly clinical financial and performance reports during departmental meetings ensuring meeting minutes were distributed to all physician and staff. Lindgren et al reported that professional fulfillment serves as a core category that drives engagement. This is gained when providers feel they achieve meaningful results and have a sense of making a meaningful impact (19).

One area that required improvement was the on-boarding process for new physician and staff hires and general workflows for administrative activities, such as submitting leave requests and so on. This resulted in developing an orientation manual with detailed workflows and standardized training for clinical and academic physicians and staff. Studies support the importance of environment factors, organizational support, assurance processes, and reward mechanisms in driving higher staff engagement (20).

Input/Engagement

Another important driver of engagement was the ability to provide input into processes and decisions that influence physician and staff's daily work. Goldstein and Ward also found that when physicians are engaged in strategic planning and in the decision-making process, they tended to be higher performers (21).

Physicians and staff felt that an external mediator was important when there are differences in opinions on work-related issues. Our team was able to disseminate resources from the Human Resources office to address this issue. In addition, APPs felt they did not have a venue to discuss issues or be part of discussions related to clinical care that pertains to their work. Advanced practice providers are now invited, and part of, departmental meetings and quality improvement initiatives. They also have monthly group meetings with the medical directors. Such team approaches also have quality benefits; for example, Kalisch et al demonstrated increased job satisfaction and improved safety measures in hospitals, such as decreased falls, due to team approaches (8).

It is difficult to invite everyone in a large department to be part of every educational program, clinical service, or other academic endeavor. Hence, we focused on regular communication in monthly combined staff and physician meetings that allowed us to share information and to also solicit feedback. Moreover, we started engaging a rotating number of departmental members in the interview process for staff, physician, and family medicine residency positions. Input when developing new job descriptions is now solicited as well.

In 2017, our department initiated a new strategy map development process that sets the department's annual trajectory through established goals and tactics. The success of this process hinged on engaging every staff and physician member to provide input into its development. At the end, the goal is to have all departmental members feel it is "their" strategy map.

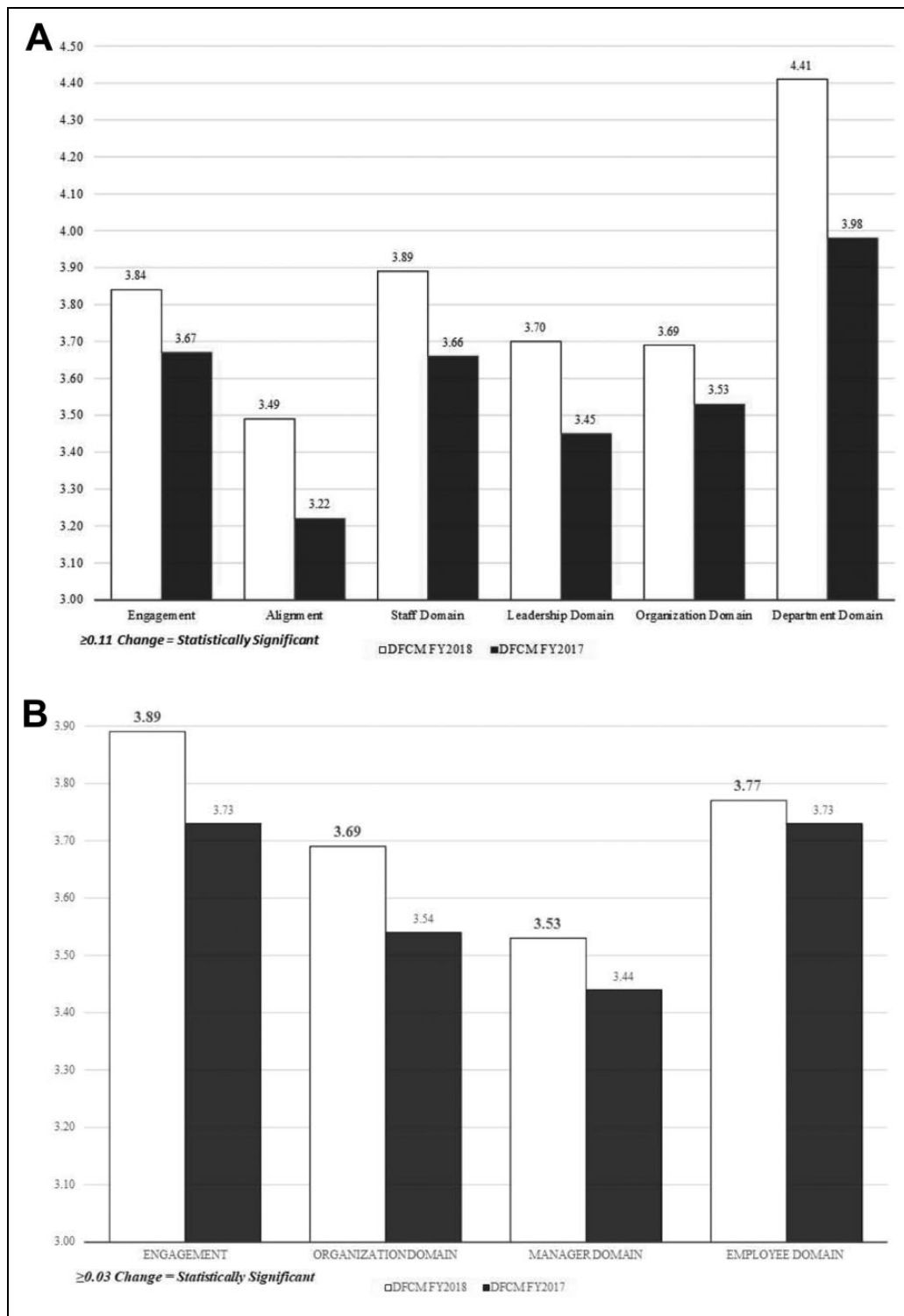


Figure 2. A, DFCM faculty/provider engagement results. B, DFCM FY2018 employee engagement results. DFCM indicates Department of Family and Community Medicine.

Valued/Safe

Staff and physicians identified simple factors that related to feeling valued. For example, long waits to use break room microwaves was found to be problematic as this took from

available break times. Hence, additional microwaves were provided. Our leadership also converted an office room into a wellness room with exercise equipment and a television for those seeking fitness activities during breaks. Again,

research has demonstrated that environmental factors do influence staff and provider engagement (22). Moreover, leadership began dissemination of virtual “Stars,” which is an online service that recognizes individuals for exemplary service and offers opportunities to gain awards and gifts through a point system. Reward systems drive a sense of value and purpose which are qualities linked to work engagement (20).

Investment in training was also a response to the engagement results. All leaders who had physicians or staff reporting to them were engaged in 4 sessions of leadership training which included skill development such as root cause analyses and giving effective feedback. Moreover, the chair of the department implemented a 6-lecture series for staff across the department with topics focused on working as a team, dealing with difficult situations, the value of feedback, and professionalism. There were 46 staff members who signed up for this popular series requiring 3 iterations over a year period. These trainings are supported by evidence that leadership behavior positively influences team engagement (18).

Conclusion

Through an in-depth exploration and a transparent process of better understanding the root factors that led to low scoring items on a quantitative engagement survey, we were able to target meaningful changes that reflected the desires and needs of our staff and physicians. This resulted in statistically significant increases in the subsequent year’s engagement survey results for both physicians and staff. More importantly, research has shown that such results have the potential to increase workplace joy, improved quality of care, and decreased burnout. We have chosen to make this an iterative annual process, as engagement is viewed as a continuous improvement practice that will drive higher quality of care and a better patient experience, which are core tenets of the Quadruple Aim.


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