WORKFORCE DESIGN TOOLKIT · 01 OF 04

Workforce Design Diagnostic

Twenty questions for deciding where to look, plus a facilitated version for running it with a team.

SETTING SCORED _____ COMPLETED BY _____ ROLE _____ DATE _____

What this is. A structured conversation tool for deciding where a team should look for modifiable conditions of work.
What it is not. Not a validated burnout measure, not a psychometric instrument, not a diagnostic test, not a causal model, and not a substitute for formal wellbeing assessment.

How to use it

Pick **one defined setting** and score it: a single clinic, residency practice, care team, pod, service line or workflow. Scoring "the organization" produces an average that describes nobody.

Rate each of the twenty statements from 1 to 5. **Lower ratings suggest a concern worth investigating; higher ratings suggest a perceived strength. Ratings are not validated cut points.**

Never total the domains. There is no validated composite score, threshold or benchmark. The 1 to 5 ratings are prompts for structured reflection and comparison of perspectives within one defined setting. They are not a validated measure of resilience, burnout or organizational performance. A scored instrument would imply a precision this does not have.

01 CAPACITY

Can available resources reasonably meet expected demand?

Work demand can usually be completed within available time and resources.	1 2 3 4 5
Staffing and coverage are aligned with predictable demand variation.	1 2 3 4 5
Administrative and asynchronous work are counted in workload design.	1 2 3 4 5
Work not requiring clinician judgment is consistently handled by the appropriate team member.	1 2 3 4 5

Where is demand exceeding available capacity?

What data would show whether this is truly a capacity problem?

02 CONTROL

Do people have appropriate influence over the work for which they are accountable?

Team members have meaningful input into workflows that affect their work.	1 2 3 4 5
Clinicians have appropriate influence over workload, scheduling and task allocation.	1 2 3 4 5
Accountability is matched with sufficient authority to address operational barriers.	1 2 3 4 5
Frontline staff are involved when work processes are redesigned.	1 2 3 4 5

Where does responsibility exceed influence or control?

03 WORKFLOW

Does work reach the right person at the right time with minimal avoidable friction?

Tasks are usually routed correctly the first time.	1 2 3 4 5
Work rarely requires unnecessary handoffs or duplicate review.	1 2 3 4 5
EHR processes support rather than obstruct completion of work.	1 2 3 4 5
Standardizable work has clear pathways and escalation criteria.	1 2 3 4 5

Where does work repeatedly wait, loop or require rework?

Where is work routinely completed after scheduled work time?

04 TEAM

Are roles, responsibilities, delegation and handoffs intentionally designed?

Team members understand which role owns which tasks.	1 2 3 4 5
Delegation is reasonably consistent across clinicians and teams.	1 2 3 4 5
Team members generally work at an appropriate level of training and scope.	1 2 3 4 5
Handoffs and escalation pathways are explicit.	1 2 3 4 5

Where is unclear ownership creating duplication, delay or unnecessary escalation?

05 LEADERSHIP

Do leaders identify and remove barriers to effective work?

Team members can raise operational problems without unnecessary interpersonal risk.	1 2 3 4 5
Problems raised by frontline teams receive visible follow-through.	1 2 3 4 5
Leadership considers workload consequences before adding new expectations.	1 2 3 4 5
New initiatives are accompanied by decisions about what can stop, change or simplify.	1 2 3 4 5

What recurring barrier has the organization learned to work around rather than fix?

Where to look first

My two priority domains to investigate

What evidence already supports these priorities?

What evidence is still missing?

Where are people compensating for poor design?

> The framework tells you where to look. It does not diagnose the organization for you.

Running it with a group

The diagnostic is far more informative completed by several roles independently than by one person alone. Ask an attending, a resident, a nurse, a medical assistant and a front-office team member to score the same setting without conferring.

> **When several roles rate the same setting independently, differences between roles can be especially informative.**
> A wide range may indicate that the same workflow or operating condition is experienced or observed differently across roles. Treat that disagreement as a hypothesis-generating signal and investigate it before drawing conclusions.

Record the **median** and the **range** for each domain as facilitation aids, not validated metrics. **Discuss the widest range first** and ask what each role is seeing that others may not see. Do not average the disagreement away.

DOMAIN	MEDIAN	LOWEST	HIGHEST	WHERE DID PERSPECTIVES DIVERGE, AND WHAT MIGHT EXPLAIN THE DIFFERENCE?
Capacity				
Control				
Workflow				
Team				
Leadership				

The widest range was in which domain, and what did that conversation surface?

Scope, and its edge

These five domains cover **modifiable operating conditions**. That scope is deliberate and it has an edge worth naming.

Burnout is multifactorial. Distress arising from values misalignment or moral injury, the experience of being constrained from delivering care you consider adequate, is real, is frequently described in family medicine, and is **not** reducible to workflow design. It is sometimes downstream of the same operating conditions and sometimes not. Where it is not, it needs different levers than the ones in this toolkit.

A framework claiming to cover everything would be less useful, not more. This one covers the conditions of the work. **Support people. Redesign the work.** Both, not either.

Disclosure. Dr. Bains is Founder and CEO of Energized Vision. He has no relevant financial relationships with ineligible companies to disclose. The STFM session this accompanies is educational and is not a commercial presentation.

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