

Developing an Organizational Health Assessment Framework

Insights from Mental Health Screening Tools

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Abstract

We propose an Organizational Health Assessment (OHA) framework inspired by brief mental health screening tools like the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7). By conceptualizing organizations as complex adaptive systems, the OHA draws parallels between individual mental health and organizational functioning. We outline the framework's theoretical foundations, components, and practical implications for research and practice. Grounded in actionable insights, this approach aims to be both empirically rigorous and immediately useful for organizational leaders to gauge workplace health. Like mental health screenings that flag symptoms for further investigation, the OHA detects patterns in organizational functioning as early indicators of potential issues rather than pinpointing root causes. Designed to help bridge the research–practice gap in industrial–organizational psychology, the OHA provides a concise, evidence-based tool for regularly monitoring and improving organizational health.

Keywords

organizational health, complex adaptive systems, psychometric assessment, mental health screening, industrial-organizational psychology

Significance and Practitioner Points

- The OHA framework offers a concise, regular “health check” for organizations, analogous to individual mental health screenings, enabling early detection of potential organizational issues.
- By applying complexity science principles, the OHA captures emergent dynamics in organizations and bridges the gap between academic research and practical management tools.
- Practitioners can integrate the brief OHA survey into routine workflows to monitor organizational well-being and drive data-informed interventions.
- Using OHA results to prompt targeted follow-ups and improvements can enhance employee engagement, adaptability, and overall organizational resilience.

Introduction

Industrial–organizational (I–O) psychology is grappling with how to assess and improve the “health” of organizations in a complex, rapidly changing world. We propose an Organizational Health Assessment (OHA) framework inspired by the success of two short mental health instruments—the PHQ-9 and GAD-7, brief validated screening tools for depression and anxiety (Kroenke et al., 2001; Spitzer et al., 2006). By analogy, we ask: Can a similarly concise and rigorous tool be developed to assess an organization’s overall

well-being?

Our central argument is that organizational scholars and practitioners can draw valuable insights from complexity science and psychometric screening to fundamentally rethink how we measure organizational effectiveness. As discussed in Section , definitions of organizational health vary, but converge on the idea that sustainable performance and employee well-being must be considered together.

Integrating a psychometric approach with complex adaptive systems (CAS) principles, the OHA fills a gap by providing holistic, frequent, and actionable snapshots of organizational health. In doing so, it sits at the intersection of debates on measuring complex constructs, applying complexity theory in organizations, and improving research–practice integration.

This paper outlines the theoretical foundations of the OHA (linking individual mental health and organizational dynamics), presents the OHA framework and its components, connects the OHA to key debates in I–O psychology (measurement challenges, complexity science, and the scientist–practitioner divide), and discusses practical implications and future research directions. Our goal is to provoke conversation: Can the simplicity and power of brief psychometric tools like the PHQ-9 inspire an effective, concise measure for organizational health? We invite both enthusiasm and skepticism in exploring this question.

Defining Organizational Health

Although the importance of organizational health is widely acknowledged, its precise definition varies across contexts. Miles (1965) described a healthy organization as one that not only survives but competently adapts and develops over the long term. Cooper and Cartwright (1994) emphasized that healthy organizations are simultaneously financially prosperous and composed of healthy, satisfied employees. More recent perspectives integrate these views, framing organizational health as both the ability to perform sustainably and to maintain positive employee well-being (Grawitch et al., 2006; Keller & Price, 2011; Lowe, 2010). In practice, organizational health is often defined as an organization's capacity to align on goals, execute effectively, adapt to change, and sustain a supportive work environment. Despite definitional differences, a broad consensus exists that healthier organizations exhibit stronger long-term performance and resilience.

Theoretical Foundations: Individuals and Organizations as Complex Systems

Human Psychology as a Complex Adaptive System

Contemporary psychological science recognizes that mental health emerges from complex, nonlinear interactions among cognitive, emotional, biological, and social subsystems (Borsboom, 2017). No single factor solely determines well-being; even small changes in one domain can trigger outsized effects on overall mental health. CAS theory highlights adaptation and self-organization: human psychological systems adjust to disturbances and may settle into new equilibria—some of which are maladaptive (e.g., chronic anxiety).

This CAS perspective has led to brief diagnostic tools like the PHQ-9 and GAD-7 that sample a few key symptoms to gauge an individual's mental state (Kroenke et al., 2001; Spitzer et al., 2006). Despite their brevity, these tools reliably flag when the system is trending toward pathology, enabling early intervention. The PHQ-9's nine items, for example, capture core depressive symptoms (low mood, loss of interest, low energy, etc.) and have been extensively validated across populations (Carroll et al., 2020). The success of such tools demonstrates that even complex, emergent phenomena can sometimes be monitored with simple, well-targeted metrics.

Organizations as Complex Adaptive Systems

Organizations similarly function as CAS comprised of interdependent elements—people, teams, processes, technology, and culture—whose interactions give rise to emergent outcomes. Organizational health is not driven by any single factor; it emerges from dynamic feedback loops among these parts (Kozlowski et al., 2013; Schneider & Somers, 2006). Even slight changes in one area (say, communication patterns or technology use) can cascade into large shifts in productivity or morale, illustrating nonlinear dynamics. Organizations also adapt and self-organize, sometimes settling into new equilibria that may be maladaptive (for instance, a minor policy change inadvertently fostering a toxic subculture).

Viewing organizations through a CAS lens under-

scores the need for holistic assessment tools. Traditional metrics (financial KPIs, engagement scores, etc.) often focus on isolated facets of performance. A complexity perspective suggests we should also gauge systemic “health”—the organization’s adaptive capacity and the alignment among its parts (Schneider & Somers, 2006). This is analogous to evaluating an individual’s overall well-being rather than just one vital sign. By “screening” an organization’s health similar to how we screen individual mental health, we can gain an integrated understanding of its state. Brief, regular assessments could provide insight into an organization’s evolving health and resilience.

In sum, individual psychology and organizational dynamics both involve complex, adaptive processes that can be monitored through carefully chosen indicators. However, just as the PHQ-9 is not a full clinical diagnosis, the OHA is not a substitute for comprehensive organizational analysis. It is an early detection tool to highlight patterns that warrant deeper investigation. Its value lies in providing quick, systematic insights that guide where to look next—without claiming to reveal root causes on its own.

Systems Pathology and Organizational Health

In developing the OHA, we drew conceptual inspiration from systems engineering research that applied a medical pathology lens to organizational dysfunction. Davidz et al. (2018) introduced the idea of Systems Engineering (SE) Pathology, extending the medical notion of pathology to characterize dysfunctions in complex socio-technical systems. They explicitly analogized diagnosing SE issues to diagnosing disease, suggesting that just as medicine has accumulated knowledge of diseased states, fields like systems engineering can accumulate knowledge of causes, detection, and treatments for dysfunctional execution. This cross-domain perspective provided a bridge between medical models and organizational analysis, prompting us to consider organizations themselves as patients that can exhibit “health” or “pathology.”

Building on this analogy, we linked mental health questionnaire frameworks to the assessment of organizational health. If an organization can exhibit pathologies, one can attempt to “screen” for those issues just as brief instruments (e.g., PHQ-9, GAD-7) screen for individual mental health

symptoms. Accordingly, the OHA adapts insights from such tools to detect organizational dysfunctions early. Moreover, we structured the OHA’s domains by drawing directly from the pathology groupings identified by Davidz et al. (2018). In their work, four broad categories of SE dysfunction were proposed—Knowledge/Understanding, Organization, Resources, and Implementation—which map closely to our OHA domain structure. For example, the OHA includes items on knowledge clarity, resource adequacy, and execution reliability, directly mirroring those categories; meanwhile, the broad “Organization” category is split into multiple domains (e.g., leadership and culture) to capture additional facets of organizational health.

The Proposed OHA Framework

Translating Mental Health Dimensions to Organizational Health

Designing an OHA begins by identifying organizational analogs to key dimensions of individual mental health. Table 1 illustrates five foundational parallels:

Cognition and Beliefs → *Organizational Culture & Mental Models*: Just as an individual’s thoughts and core beliefs shape personal well-being, an organization’s shared values and norms (collective “mental models”) guide behavior. For example, an individual’s irrational belief can cause distress; similarly, a dysfunctional norm like “we must not admit mistakes” can undermine organizational health (Argyris, 1977; DeChurch & Mesmer-Magnus, 2010).

Emotions and Mood → *Climate & Morale*: An individual’s emotional state (happy, anxious, depressed) is mirrored at the organizational level by the prevailing work climate and employee morale. High trust and engagement versus pervasive stress and cynicism correspond to positive versus negative collective moods (Frazier et al., 2017).

Behavioral Patterns → *Organizational Routines & Processes*: Maladaptive personal behaviors (e.g., avoidance or rumination) have parallels in rigid or counterproductive organizational routines that hinder adaptation. An individual stuck in rumination is akin to a company bogged down in bureaucratic procedures that stifle learning (Pentland et al., 2012).

Biological Factors → *Infrastructure & Technology*: Just as neurobiological factors can enable or constrain an individual’s functioning, an organization’s techno-

logical and structural infrastructure (IT systems, organizational design, physical workspace) serves as its underlying “hardware.” Well-aligned infrastructure enables smooth operations, while misaligned or outdated infrastructure can impair the organizational system (Benbya & McKelvey, 2006; Weber & Waeger, 2017).

Feedback Loops → Communication & Metrics: Individuals can get trapped in vicious cycles (e.g., negative self-talk fueling anxiety); likewise, organizations can suffer from dysfunctional feedback loops in communication and performance metrics.

By mapping these domains, the OHA framework spans cognitive (culture/mental models), affective (climate/morale), behavioral (processes/routines), structural (infrastructure), and feedback-related (communication/metrics) aspects of organizational functioning. Together, these dimensions capture much of an organization’s overall health. An effective OHA instrument would include items or subscales targeting each domain, analogous to how the PHQ-9 covers multiple symptoms of depression.

OHA Components and Example Indicators

Building on the above analogs, we propose an initial set of OHA content areas and sample items that operationalize organizational health in a concise survey format. Our framework assesses organizational health across six key domains:

Knowledge and Understanding: Do employees understand their roles, responsibilities, and the company’s goals? (e.g., “My responsibilities are clear and well-communicated.”)

Process Maturity: How well-defined and adaptable are the organization’s processes? (e.g., “When issues arise in our workflows, they are addressed and improved in a timely manner.”)

Resource Allocation: Are resources (people, tools, time) adequate and fairly distributed? (e.g., “My team has the tools and resources we need to succeed.”)

Leadership and Decision-Making: Do leadership practices encourage evidence-based decisions and value employee input? (e.g., “Management values employee feedback and acts on it when appropriate.”)

Culture and Collaboration: Does the culture support trust, innovation, and cross-team collaboration?

(e.g., “Our organizational culture supports learning and open communication.”)

Implementation and Execution: Can the organization reliably execute plans and manage disruptions? (e.g., “Projects in my area are completed on time and meet quality expectations.”)

Each domain is measured using a small set of survey items (roughly 3–4 per domain) rated on a Likert-type scale (for example, 0 = Not at all true, up to 3 = Completely true). Unlike the PHQ-9, which uses negatively framed symptom statements to highlight problems (Kroenke et al., 2001), our OHA items are phrased in positive terms to reduce response bias (Weijters & Baumgartner, 2012). In practice, lower scores in any domain would signal potential “health issues” in that facet of the organization—analogous to how symptoms like low energy or poor appetite indicate possible depression in an individual.

Importantly, the OHA is intended to be comprehensive yet brief. Our prototype survey consists of about 18–20 core items (yielding a total score, e.g., out of 54) that an employee can complete in just a few minutes. Brevity is critical for frequent use without causing survey fatigue. Despite its brevity, the OHA aims to capture a holistic picture: a high total score indicates a resilient, well-functioning organization, whereas a low total score flags systemic problems requiring attention. We envision using score benchmarks (similar to PHQ-9 cutoffs) to categorize organizational health levels—for example, an OHA score in the very low range might indicate serious, widespread issues, while a very high score suggests robust health and a culture of continuous improvement (Kroenke et al., 2001).

Another feature we propose is using targeted follow-up questions when a particular domain is rated poorly. If a respondent gives a low score in any domain, the survey can immediately ask how much that issue hinders key outcomes (such as meeting customer commitments, maintaining quality, or keeping employees engaged). This mirrors a clinician following a positive depression screen with questions about functional impairment. These follow-ups help quantify the impact of the problem. For example, if poor Process Maturity is reported to make it “very difficult” to maintain quality, that issue demands urgent action. Follow-up items thus create a bridge between initial symptom recognition and the deeper causal exploration that should follow. By linking low ratings to important outcomes, the OHA also prompts

reflection and buy-in from respondents, encouraging employees to engage in the process of improvement.

Related Frameworks for Assessing Organizational Health

Several established frameworks already aim to capture organizational health, against which the OHA can be compared.

McKinsey's Organizational Health Index (OHI)

McKinsey's Organizational Health Index (OHI) is a widely used diagnostic tool assessing nine dimensions of health, including leadership, direction, accountability, motivation, coordination and control, capabilities, external orientation, and learning/innovation (McKinsey & Company, n.d.). It relies on employee surveys benchmarked across a global database and has been linked in practitioner reports to long-term business performance; McKinsey reports that healthy organizations, as measured by OHI, are approximately three times more likely to outperform their less healthy peers.

Denison Organizational Culture Model

The Denison Organizational Culture Survey (DOCS) measures four cultural traits—Mission, Adaptability, Involvement, and Consistency—that have been shown to predict effectiveness (Denison, 1990). Unlike the OHI's management-practice emphasis, the Denison model centers on cultural alignment as a key determinant of organizational health. Both frameworks highlight that sustained success arises from the interplay of clear direction, adaptable processes, and engaged employees.

Positioning the OHA

The OHA differs from both OHI and Denison by explicitly adopting a psychometric screening analogy (e.g., PHQ-9, GAD-7). Whereas OHI provides comprehensive benchmarking and Denison emphasizes culture, the OHA offers a brief, repeatable "health check" intended to flag emerging dysfunctions. Thus, the OHA complements existing frameworks by prioritizing brevity, frequency, and early de-

tection.

Ensuring Rigor: A Multi-Level, 360° Assessment

For the OHA to be credible, it must meet rigorous psychometric standards. A major design principle is that the OHA should be applicable across hierarchical levels—from frontline employees to executives—to capture a full 360-degree perspective. This raises the challenge of measurement equivalence: we must ensure the items have consistent meaning and measurement properties for different groups (e.g., hourly staff vs. managers). Establishing measurement invariance across subgroups will be a key part of validation (Putnick & Bornstein, 2016). We also anticipate iterative testing and refinement of items (using factor analyses and item-response theory) to confirm that the OHA's structure holds in diverse samples.

Notably, if an assessment yields uniformly high or stable scores across groups or time, it may indicate either consistently good health or a lack of sensitivity. Evidence and implications for sensitivity and discriminant validity are discussed in Section . Accordingly, we design the OHA to pick up meaningful variation by (a) sampling multiple dimensions beyond a single engagement factor and (b) securing multi-perspective data (e.g., frontline, supervisory, executive) to increase the probability of detecting true differences across teams and time.

Including multiple viewpoints also allows the OHA to uncover misalignments within an organization. For instance, if senior leaders rate the organization's adaptability much higher than frontline staff do, it flags a disconnect between strategic vision and ground-level reality. Such discrepancies are themselves informative and underscore the value of methodological triangulation—integrating multiple data sources to enhance validity (Jick, 1979).

Finally, just as the PHQ-9 had to demonstrate clinical validity, the OHA must demonstrate organizational validity. We plan to establish this by correlating OHA results with independent performance indicators (e.g., productivity metrics, turnover rates, customer satisfaction). Over time, a validated OHA could potentially serve as a leading indicator of organizational decline or success—much like a rising PHQ-9 score can predict risk of depression relapse. In short, our framework combines conceptual mapping with careful measurement development to create a

tool that is both scientifically sound and practically useful.

Key Debates and Challenges in I–O Psychology

Measurement Challenges: Can Complex Constructs Be Measured Simply?

A central debate in I–O psychology is whether a complex construct like “organizational health” can be validly captured in a short survey. Developing reliable and valid short-form measures is notoriously difficult (Hinkin, 1998), and performance measurement systems often face trade-offs between complexity and usability (Franco-Santos et al., 2012). Key concerns include content validity (are all relevant facets of organizational health covered?), construct validity (does an OHA score correspond to meaningful differences in outcomes?), and sensitivity (can a short survey detect changes over time?).

Indeed, some empirical evidence has cast doubt on the sensitivity of brief pulse surveys. Brown (2022) reported that in one organization, frequent engagement pulse surveys provided stable scores across eight months with practically no between-group differences, suggesting limited ability to detect change or variation with such an approach. The pulse survey’s items also showed poor discriminant validity, essentially collapsing into one general factor of “engagement.” Such findings caution that brevity can come at the expense of nuance if not carefully designed.

Our stance remains optimistic—parsimonious measures can succeed if grounded in strong theory. The PHQ-9 and GAD-7 emerged from careful distillation of diagnostic criteria and prove that brevity and validity can coexist. Similarly, we anchored the OHA in well-established organizational dimensions (culture, climate, etc.) to ensure broad coverage. We deliberately focus on emergent, higher-order characteristics (like adaptability, alignment, and climate) that integrate many lower-level details, sacrificing some specificity for a holistic view of system wellness.

To ensure validity, we call for rigorous psychometric work: iterative pilot testing, factor analyses, and validation studies in multiple organizations. Advanced analytics can test whether a general factor of “organizational health” emerges and how it re-

lates to sub-factors. If our initial domain set is incomplete or too coarse, the OHA will require refinement. We acknowledge that a single summary score could mask important nuances. However, we view the OHA as a complementary tool, not a replacement for deeper analysis. Much like a quick vital sign check doesn’t capture all aspects of health but is still useful, an OHA score can serve as an informative snapshot that flags where further examination is needed. Ultimately, the OHA’s utility will be determined by empirical evidence from validation research.

Complexity Science in I–O: Novelty or Necessity?

Another debate concerns importing complexity science concepts into mainstream I–O psychology. Some argue that labeling organizations as CAS is trendy jargon with little practical value, while others contend that traditional linear models fail to capture the reality of organizational dynamics (Levy, 2000; Richardson, 2008; Uhl-Bien et al., 2007). We align with the latter view: a complexity lens is a necessary perspective for understanding modern organizations. By explicitly framing organizations as CAS, we encourage thinking in terms of systems, interactions, and emergence rather than isolated factors.

This perspective changes how we approach organizational issues. Instead of addressing problems one by one in silos, a CAS approach examines patterns and feedback loops. For example, low scores in both Resource Allocation and Morale might indicate a vicious cycle of strain and disengagement—limited resources frustrate employees, leading to low morale and further inefficiencies. A complexity-minded intervention would seek a systemic solution (e.g., redistributing workloads or redesigning processes) to break this cycle, rather than tackling each symptom separately.

Complexity thinking also underscores the importance of continuous monitoring and adaptation. Because CAS dynamics can change rapidly and nonlinearly, a one-time assessment has limited value. This insight influenced our emphasis on frequent OHA “health check-ups”—organizations might measure their vitals quarterly or even monthly rather than annually. Frequent assessments can reveal trends or sudden shifts that a yearly survey would miss, and they can quickly show the impact of changes (sometimes a small policy tweak yields a surprisingly large jump in morale, for instance).

While complexity science in I–O is still emerging, it echoes calls for more dynamic, multilevel methods in organizational research. The OHA can facilitate this by providing regular data points for time-series or network analyses of organizational dynamics. For example, data from recurring OHA surveys could be analyzed for tipping points or cascade effects. Embracing this complexity perspective may challenge practitioners to think beyond simple cause–effect models, but in today’s turbulent environment, we believe it is increasingly essential.

Practitioner Adoption: Bridging the Research–Practice Divide

Perhaps the greatest challenge for any new framework is practitioner adoption. I–O psychology has long noted the gap between research and practice (Rynes et al., 2007). Will HR professionals, consultants, and executives actually use the OHA, or will it remain an academic exercise? We designed the OHA with real-world usability in mind, focusing on three factors:

Brevity and Ease of Use: The OHA is intentionally short and simple to administer—a nonnegotiable requirement for busy workplaces already inundated with surveys. A new tool will gain traction only if it adds value without adding burden. We envision integrating the OHA into existing routines (e.g., quarterly performance check-ins or pulse surveys) (Mone & London, 2018). The PHQ-9’s widespread use in primary care demonstrates the power of brevity and convenience (Kroenke et al., 2001). Likewise, the OHA would be a quick online questionnaire with instant scoring, yielding an easy-to-read dashboard of results. Managers might see which domains are green, yellow, or red—much like an organizational “check engine” light.

Face Validity and Relevance: Practitioners are more likely to trust a tool that measures concepts they intuitively recognize as important. We chose OHA domains and phrased items in plain, business-relevant language (e.g., alignment, resources, collaboration) to avoid academic jargon. A well-designed OHA report should resonate with a manager’s gut sense of the organization’s issues and strengths, while adding breadth and structure to that intuition. The notion of an “organizational health score” is inherently appealing—consulting firms have already popularized the term as key to performance (Keller & Price, 2011). Our contribution is to give that idea sci-

entific teeth and a user-friendly measurement tool.

Demonstrable Value: Practitioners will ask whether improving OHA scores actually leads to better outcomes. We encourage formal research on this (see Future Research), but early adopters can also pilot the OHA and track their own metrics. For example, an organization might roll out the OHA quarterly and observe whether units that improve their OHA scores also see gains in customer satisfaction or employee retention. Additionally, OHA results can be a powerful conversation starter and intervention tool. Sharing the feedback with employees and committing to action shows that leadership is listening, which can boost engagement and trust. Involvement in the process can counter the cynicism that often greets surveys that yield no visible changes.

Of course, we must also acknowledge potential objections. Some may worry that the OHA oversimplifies complex dynamics or could be misused (e.g., if leaders obsess over a single score as a vanity metric). Others might resist frequent surveys due to fatigue or fear of exposing problems. These issues can be mitigated. To reduce burden, organizations might rotate participants or use sampling rather than surveying everyone every time. To prevent misuse, it’s crucial to frame the OHA as a developmental tool, not a compliance exercise—leadership should emphasize that the goal is to identify and improve weak spots, not to assign blame.

Practical Implications for Organizations

Embedding OHA into Organizational Routines

If adopted, the OHA could become a regular organizational “health check,” analogous to routine medical check-ups for individuals. An ideal implementation might involve administering the OHA on a recurring basis (e.g., quarterly) to all employees or to a rotating sample. With modern survey tools, this can be done via email or an internal portal, with automatic aggregation of results. Because the instrument is very brief, participation should be reasonable—especially if leaders communicate its importance and act on the findings. The OHA can be integrated into existing management processes: for example, leadership teams might review OHA results in quarterly meetings and incorporate the insights into planning

and decision-making.

One key advantage of frequent assessment is the ability to track trends over time. Instead of a once-a-year employee survey that provides a static snapshot, the OHA produces a moving picture of organizational health. This helps leaders detect early warning signs before they become crises. For instance, if the Culture & Collaboration domain shows a steady decline over two quarters, it might foreshadow a spike in turnover or rising conflict. With OHA data in hand, management could investigate and address underlying causes (perhaps growing silos or burnout) before the situation worsens. In this way, the OHA functions as a proactive risk identification system.

Regular OHA monitoring also aids in change management and intervention evaluation. Organizations constantly implement changes (new tools, reorganizations, initiatives) and often struggle to gauge their holistic impact. By comparing OHA results before and after a major change, leaders can see whether the change coincided with improvements or dips in certain health domains. If a restructuring is followed by a drop in Resource Allocation scores, for example, it signals resource strain or confusion that needs attention. Moreover, because the OHA includes follow-up questions linking low scores to outcomes, organizations can prioritize issues based on impact. If poor Process Maturity is reported to be making it “extremely difficult” to meet customer commitments, that area should receive immediate focus.

Beyond its diagnostic value, the very process of using the OHA can improve internal communication and alignment. Sharing OHA results (appropriately aggregated to ensure anonymity) creates a common language around organizational health. It democratizes diagnosis by involving voices at all levels, which can increase buy-in for subsequent improvements. Simply conducting regular health check-ups sends a signal that leadership cares about systemic well-being, not just short-term financial metrics. Over time, this transparency and responsiveness can build trust—employees see their feedback valued and acted upon—and foster a culture of continuous improvement. An organization that routinely takes its health “pulse” and follows through on the findings is likely to be more change-ready and resilient.

Potential Benefits

Implementing a validated OHA framework can yield several benefits:

Data-Driven Decision Making: Quantified health metrics on each dimension help leaders make evidence-based decisions about where to focus attention or resources. For example, if Leadership & Decision-Making scores are consistently low (especially in a particular department), it provides justification to invest in management training or adjust decision-making processes in that unit. The OHA turns soft, qualitative perceptions into hard data that can be tracked over time, bringing analytic rigor to organizational development efforts.

Adaptability and Agility: Regularly assessing barriers to adaptability (like rigid processes or low trust) helps organizations identify and address them proactively. The OHA highlights impediments to change (e.g., poor communication channels or unclear roles) so they can be fixed, thereby improving the organization’s capacity to respond to external turbulence. Over time, this deliberate attention to “health” factors cultivates greater agility and resilience.

Alignment and Engagement: By collecting input across levels and feeding results back, the OHA can improve alignment between employees and leadership. It creates a feedback loop where leaders hear employee concerns and can respond, making employees feel heard and valued. This participative approach can boost engagement, as people see their input leading to tangible action. Involving staff in monitoring organizational health also fosters a more inclusive, improvement-oriented culture.

These benefits depend on using OHA results constructively. Simply gathering data without follow-through can breed cynicism and undermine trust. Thus, the OHA should be part of a continuous improvement cycle: measure, reflect, act, and then measure again to see if actions helped. In essence, the OHA can embed a Plan–Do–Check–Act discipline into the organization’s management routines.

Caveats and Considerations

Several practical considerations must be managed for the OHA to deliver on its promise:

Survey Fatigue: Frequent surveys risk fatiguing employees. To mitigate this, the OHA must remain extremely brief (as designed) and perhaps use smart sampling (not everyone, every time—rotating “pulse” surveys can distribute the burden). Clear communication about the purpose of regular check-ins can also help by giving them meaning (Beebe & John-

son, 2019). When employees understand why they are providing feedback and then see changes result, they are more likely to stay engaged despite frequent surveys.

Response Bias: Even with anonymous administration, employees may be reluctant to rate their organization poorly for fear of repercussions. Emphasizing confidentiality and framing the survey as a health “check-up” (not an evaluation) can encourage honesty. It’s also useful to pair subjective perceptions with objective indicators where possible, to triangulate findings.

One Size Doesn’t Fit All: Organizations differ in their structures, cultures, and contexts. The OHA may need adaptation for different industries or sizes. While we aimed for broadly relevant domains, some customization might enhance validity in certain settings (for instance, adding items about safety for a manufacturing firm). Any benchmarking would also need to account for contextual factors.

Conclusions and Future Research

Future research should examine the properties and impact of the OHA in diverse contexts. Longitudinal studies can test its ability to predict key outcomes (e.g., does a drop in OHA scores precede performance declines or turnover spikes?). Experimental trials could assess whether interventions that improve OHA scores also improve objective outcomes, strengthening claims of causality. It will also be important to compare the OHA with existing organizational assessment frameworks (e.g., the Balanced Scorecard (Kaplan & Norton, 1996)) to clarify its unique contributions and any overlap. Such comparisons can highlight what the OHA adds beyond traditional performance metrics or employee engagement surveys.

Attention is also needed on effective implementation. How can organizations best introduce the OHA to employees, act on the results, and integrate the tool into ongoing management practices? Research on change management suggests that how a tool is rolled out can influence its success. Studying organizations that pilot the OHA will provide insights into best practices for gaining buy-in, ensuring honest feedback, and avoiding misuse of the data.

In sum, the OHA is not a panacea that will magically solve organizational problems—but it could

change how organizations and I–O professionals talk about and address those problems. By making an evidence-based “pulse” of organizational health a regular part of management, organizations can become more proactive and data-driven in maintaining their well-being. We welcome critiques, refinements, and alternative viewpoints on this proposal. Through continued debate, feedback, and empirical testing, we will learn whether the OHA—or some evolved version of it—can become an enduring tool that helps organizations thrive in an ever more complex world.

References

- Argyris, C. (1977). Double loop learning in organizations. *Harvard Business Review*, 55(5), 115–125. <https://hbr.org/1977/09/double-loop-learning-in-organizations>
- Beebe, T. J., & Johnson, T. P. (2019). Doing something about survey fatigue. *Survey Practice*, 12(1), 1–10. <https://doi.org/10.29115/SP-2019-0004>
- Benbya, H., & McKelvey, B. (2006). Using coevolutionary and complexity theories to improve IS alignment: A multi-level approach. *Journal of Information Technology*, 21(4), 284–298. <https://doi.org/10.1057/palgrave.jit.2000080>
- Borsboom, D. (2017). A network theory of mental disorders. *World Psychiatry*, 16(1), 5–13. <https://doi.org/10.1002/wps.20375>
- Brown, M. I. (2022). Investigating the promise and pitfalls of pulse surveys. *Industrial and Organizational Psychology*, 15, 137–149. <https://doi.org/10.1017/iop.2021.124>
- Carroll, H. A., Hook, K., Rojas Perez, O. F., Denckla, C., Cooper Vince, C., Ghebrehiwet, S., Ando, K., Touma, M., Borba, C. P., Fricchione, G. L., & Henderson, D. C. (2020). Establishing reliability and validity for mental health screening instruments in resource-constrained settings: Systematic review of the PHQ-9 and key recommendations. *Psychiatry Research*, 291, 113236. <https://doi.org/10.1016/j.psychres.2020.113236>
- Cooper, C. L., & Cartwright, S. (1994). Healthy mind; healthy organization: A proactive approach to occupational stress. *Human Relations*, 47(4), 455–471. <https://doi.org/10.1177/001872679404700405>
- Davidz, H. L., Jackson, S., & Thomas, D. (2018). Systems engineering pathology: Comprehensive characterization of systems engineering dysfunction. *INCOSE International Symposium*, 28(1), 1787–1798. <https://doi.org/10.1002/j.2334-5837.2018.00584.x>
- DeChurch, L. A., & Mesmer-Magnus, J. R. (2010). The cognitive underpinnings of effective teamwork: A meta-analysis. *Journal of Applied Psychology*, 95(1), 32–53. <https://doi.org/10.1037/a0017328>
- Denison, D. R. (1990). *Corporate culture and organizational effectiveness*. Wiley.
- Franco-Santos, M., Lucianetti, L., & Bourne, M. (2012). Contemporary performance measurement systems: A review of their consequences and a framework for research. *Management Accounting Research*, 23(2), 79–119. <https://doi.org/10.1016/j.mar.2012.04.001>
- Frazier, M. L., Fainshmidt, S., Klinger, R. L., Pezeshkan, A., & Vacheva, V. (2017). Psychological safety: A meta-analytic review and extension. *Personnel Psychology*, 70(1), 113–165. <https://doi.org/10.1111/peps.12183>
- Grawitch, M. J., Gottschalk, M., & Munz, D. C. (2006). The path to a healthy workplace: A critical review linking healthy workplace practices, employee well-being, and organizational improvements. *Consulting Psychology Journal: Practice and Research*, 58(3), 129–147. <https://doi.org/10.1037/1065-9293.58.3.129>
- Hinkin, T. R. (1998). A brief tutorial on the development of measures for use in survey questionnaires. *Organizational Research Methods*, 1(1), 104–121. <https://doi.org/10.1177/109442819800100106>
- Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, 24(4), 602–611. <https://doi.org/10.2307/2392366>
- Kaplan, R. S., & Norton, D. P. (1996). *The Balanced Scorecard: Translating strategy into action*. Harvard Business School Press.
- Keller, S., & Price, C. (2011). *Beyond performance: How great organizations build ultimate competitive advantage*. Wiley.
- Kozlowski, S. W. J., Chao, G. T., Grand, J. A., Braun, M. T., & Kuljanin, G. (2013). Advancing multilevel research design: Capturing the dynamics of emergence. *Organizational Research Methods*, 16(4), 581–615. <https://doi.org/10.1177/1094428113498117>
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613. <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Levy, D. L. (2000). Applications and limitations of complexity theory in organization theory and strategy. *Public Administration and Public Policy*, 79, 67–88.
- Lowe, G. S. (2010). *Creating healthy organizations: How vibrant workplaces inspire employees to achieve sustainable success*. University of Toronto Press.
- McKinsey & Company. (n.d.). *Organizational Health Index*. Retrieved January 17, 2026, from <https://>

// www . mckinsey . com / solutions /
orgsolutions / overview / organizational -
health-index

- Miles, M. B. (1965). Planned change and organizational health: Figure and ground. In R. O. Carlson (Ed.), *Change processes in the public schools* (pp. 11–43). Center for the Advanced Study of Educational Administration.
- Mone, E. M., & London, M. (2018). *Employee engagement through effective performance management: A practical guide for managers* (2nd ed.). Routledge. <https://doi.org/10.4324/9781315169773>
- Pentland, B. T., Feldman, M. S., Becker, M. C., & Liu, P. (2012). Dynamics of organizational routines: A generative model. *Journal of Management Studies*, 49(8), 1484–1508. <https://doi.org/10.1111/j.1467-6486.2012.01064.x>
- Putnick, D. L., & Bornstein, M. H. (2016). Measurement invariance conventions and reporting: The state of the art and future directions for psychological research. *Developmental Review*, 41, 71–90. <https://doi.org/10.1016/j.dr.2016.06.004>
- Richardson, K. A. (2008). Managing complex organizations: Complexity thinking and the science and art of management. *Emergence: Complexity & Organization*, 10(2), 13–26.
- Rynes, S. L., Giluk, T. L., & Brown, K. G. (2007). The very separate worlds of academic and practitioner periodicals in human resource management: Implications for evidence-based management. *Academy of Management Journal*, 50(5), 987–1008. <https://doi.org/10.5465/amj.2007.27169261>
- Schneider, M., & Somers, M. (2006). Organizations as complex adaptive systems: Implications of complexity theory for leadership research. *The Leadership Quarterly*, 17(4), 351–365. <https://doi.org/10.1016/j.leaqua.2006.04.006>
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. <https://doi.org/10.1001/archinte.166.10.1092>
- Uhl-Bien, M., Marion, R., & McKelvey, B. (2007). Complexity leadership theory: Shifting leadership from the industrial age to the knowledge era. *The Leadership Quarterly*, 18(4), 298–318. <https://doi.org/10.1016/j.leaqua.2007.04.002>
- Weber, K., & Waeger, D. (2017). Organizations as polities: An open systems perspective. *Academy of Management Annals*, 11(2), 886–924. <https://doi.org/10.5465/annals.2015.0152>
- Weijters, B., & Baumgartner, H. (2012). Misresponse to reversed and negated items in surveys: A review. *Journal of Marketing Research*, 49(5), 737–747. <https://doi.org/10.1509/jmr.11.0368>

Biography

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