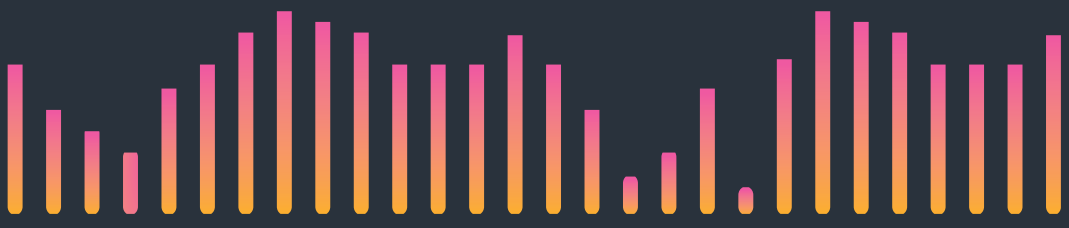
EYP

HEALTHCARE WORKPLACE CONSORTIUM

SUMMARY REPORT

Q1 2021



Introduction

Why a healthcare workplace consortium?

Improved patient care and experience. Innovation and discovery. More flexibility. Work-life balance. Increased productivity. Staff safety. Cost savings. These outcomes, and a host of others, are driving organizations to embrace new workplace strategies to support their mission and accommodate their employees, consultants and vendors. It was hard enough in "normal times" to deliver these outcomes in healthcare organizations. Now, during a pandemic, it has become especially tricky to deliver them and, in many ways, more urgent than ever.

To address these key outcomes in real time, a group of design, facilities and workplace professionals from the following health organizations got together to ask each other questions, share ideas and benefit from each other's experience.

What's in this report

This report is the second from this group. The first was completed in Q3 2020.

It includes two parts: **Key Themes** and **Survey Findings**. They were pulled from discussions with consortium participants between October and December 2020 as well as the results of a survey issued to all participants in February 2021.

What we mean when we say "workplace"

In an academic medical center, the workplace is more expansive than just office space. When we refer to workplaces in this report, we include clinical with direct patient contact, clinical without patient contact, research, education and administrative space. Inherently, the mix of these functions and spaces – their requirements and overlaps – drive issues and solutions specific to participants in this consortium.

Key Themes

Key themes include topics that were brought up by the group from the Q3 2020 Report, the following themes are still relevant:

1. **Medical centers are generally open to new ways of working.**
2. **More information is required to accommodate flexible work long-term and at scale.**
3. **It's unclear whether adopting flexible work policies will ultimately save organizations money.**
4. **The "open office" won't go away but will likely be reimagined.**
5. **Participants are testing new ways spaces can flex to support surge and different use patterns.**
6. **Cleaning staff are cleaning furniture to death.**
7. **We need to care for our caregivers.**

However, some additional themes are emerging:

8. **There is a shift towards thinking of real estate as an institution-wide resource vs. owned by department.**

Academic medical centers are trying to figure out what to do with their leased/owned office space inhabited by far fewer employees these days (and for the foreseeable future.) Should they release it, sell it, reconfigure it, let the lease run out? Will offices ever be back to full capacity? Unsure, many are taking a "wait and see" approach or looking for new and novel ways to use the space. Some are starting to think of space as institution-wide resource. Many are creating more shared space; anchoring teams to "neighborhoods."

9. **Remote work for office workers still the norm, but clearer downsides are emerging.**

While many employees have returned to work or never left (clinicians, researchers, facilities, security, cleaning, food and laundry services, etc.), others with more administrative or support staff positions remain WFH (especially call center employees, who may WFH indefinitely.) If employees do come in to work for meetings, interviews, training, etc. they may not even go to their old office, just to their intended destination. In a twist, workers who were thrilled to work at home full time in the beginning of the pandemic are now getting a bit lonely for camaraderie with colleagues. Some are becoming "workaholics" at home, putting in 14-16 hour days, sitting in back-to-back meetings, no breaks...it is taking a toll on their bodies (eyes, back, neck, joints, weight) and their mental health.

10. Worker preferences are more important, driving flexibility in policies and planning.

Employees' opinions and preferences are being listened to now as never before. The value of the individual, and their ability to self-motivate, has been newly recognized. This is leading to a "leveling" of hierarchies and a less top-down organizational structure. Some employees' value has been recognized/gone up, and they have bargaining power.

11. Communal gatherings between coworkers in the hospital have caused unanticipated spreading.

Ironically, the danger for many healthcare workers isn't just community spread, it's communing with coworkers. It seems that COVID fatigue is setting in and employees are relaxing their guard when they are with friends at work. Coworkers are getting too close in collaboration spaces or taking their masks off when they eat and drink. Whether in conference rooms, clothes-changing rooms, or cafeterias, crowded common spaces present a danger that wasn't there before, and must be accounted for.

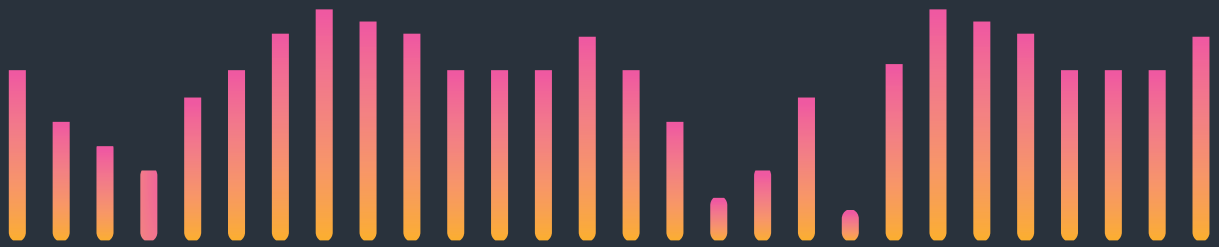
12. Measures are being taken now to reduce the impact of future outbreaks.

Medical centers don't want to be caught off guard again in the event of future outbreaks and possible pandemics. They are looking for ways to be more prepared. Lasting changes include:

- Improve air ventilation/increased air quality.
- Make clinical and office space more flexible.
- Adapt new technologies like video monitoring of patient rooms to reduce exposure.
- Move carpeting out of patient areas everywhere but physician's offices (they need carpeting because of telehealth and acoustics).
- Change doors to have windows with embedded miniblinds (curtains and exposed miniblinds are a cleaning problem) .
- Provide waiting room seats that are more spaced out or in pods.
- Provide chairs with a sense of motion to help with their anxiety, flex-back seating or glider seats allow them to move.
- Provide plexiglass panels fixed in place or suspended from the ceiling tiles (with pass-through below) at pharmacy and reception areas.
- Make WiFi and power available in parking decks for waiting patients or their families.

Survey Findings

The findings here are the results of a survey issued to all participants. Questions are highlighted in orange. Several quotes from participants have been included to help illustrate points but are intentionally not associated with a particular organization for confidentiality purposes.



RETURN TO WORKPLACE

What is the biggest "shift" in people's perception about workspace since last summer?

Medical centers, like other workplaces, quickly discovered that remote work was actually working—for them and for their employees. While this did not involve redesigning the workspace for most offices (yet) it did involve a perception shift. Managers are learning to trust staff to work virtually from home, while staff are beginning to miss their colleagues IRL.

For most, this has taken the form of a hybrid model, with some staff working at least part time in the office (following enhanced safety precautions), with others still working mostly from home. Working in the office looks different, with dedicated cubicles remaining half-vacant, restrictions on the number of people allowed in the office at the same time, and stringently enforced safety rules and regulations with workspaces and workers being monitored for compliance. Video meetings and Zoom calls have become routine and viewing the future of the office as a shared resource with flexible meeting and hoteling/workspace is becoming the norm. Care is taken to make employees both inside and outside the office feel a part of the team, and socialization and relationship building is taking place with more mindfulness and planning than during pre-pandemic times. Some workers have found work from home (WFH) preferable as a way of juggling multiple demands, a perquisite which may continue even after others return to the office.

> "There is a willingness to think of workspace as an institutional resource that will be shared by all and acceptance of sustained hybrid work model with asynchronous sharing of space when possible."

> "Users are much more used to the COVID-related constraints placed on their spaces (i.e., restriction in number of people allowed in the space for physical distancing, face mask rules for the space, signage, etc.) and these rules for the spaces are being continually checked and reinforced by a staff of 'COVID Captains' that inspect for compliance on a regular basis. Some workers (about 10% of our staff) continue to work remotely and seem to have settled into that work mode."

When do you plan to allow non-business essential staff to come back to the office?

Every medical center has its own plan for a "back to the office" repopulation strategy. Many workers are back already, since health care is fairly hands-on for most employees. But some non-essential staff are still working from home until the summer, or even fall for a few offices.

Most offices are bringing staff back on a partial or rolling basis, pending vaccine efficacy, variants, and "business essential needs to be on site. Return to work has been done in carefully planned phases, with the last phase being employees who may not be required to return but can return voluntarily if they choose.

> "To my knowledge, all departments are encouraged to 'come back to the office,' however, many continue to WFH at the discretion of each leader."

> "We started bringing staff back on campus in carefully planned phases last summer. Some staff do not require a presence on campus to conduct their work, so continue to work remotely. Plans are being implemented for most of those groups to continue in a remote workforce plan indefinitely."

How are you planning to accommodate hybrid team collaboration--as some people come back to office/ some stay at home?

How to foster and accommodate hybrid teams is still being researched by many academic medical centers. Currently, each department is assessing what the best approach is for their staff and will evaluate the services they provide as to which can be done remotely and which should be done by staff physically in the office. Even teams on campus may not meet with each other in person, in the interest of social distancing. In some centers, the workforce is being divided into primary remote, hybrid remote, and fully in office. Primary remote spends most of their time working from home, coming in once a week or less, while hybrid remote comes into the office two to three times a week. This allows for unused office space to be reclaimed for new employees, and more variety and number of common spaces. The challenge will be to keep colleagues connected even when they are not in the same space at the same time.

> "We're using seat sharing ratios (which haven't been finalized yet) such as 2:5 for hybrid and 1:5 for primary remote workers, to plan for hoteling spaces. And we'll try to group the hoteling staff and locate them in a somewhat central space in each building, which will allow us to recoup some previously assigned spaces for other growth and new initiatives and additional collaboration space."

> "In general, I expect that work from home will be one of the choices within a broader model that supports 'work anywhere' over a binary (either work from home or on-site) view. Long-term, full- time work from home would negatively impact sense of belonging and community between colleagues and with the institution, unstructured and ad hoc learning from others, social interaction, well-being and mental health, and ideation and innovation."

Has your organization changed its tune with regard to accommodating staff who work from home? Are you providing technology, furniture, training, stipends, etc.?

Managers are becoming much more accepting of flex work arrangements as the norm rather than the exception. Much of the anxiety around WFH has faded. Human Resources is training staff and management on WFH and IT is doing in-depth training on Microsoft Teams to ensure that all staff are comfortable with the primary platforms they are now working on. Computers, monitors, docking stations, and specific software are provided. Furniture for use at home is being provided through vendors or stipends by some, and not by others. Some medical centers have ergonomic specialists who have virtual training sessions and are assessing home-based office set ups and making recommendations.

> "We have not really 'changed our tune' regarding support of the remote workforce. Tremendous support was set up back in the spring last year, when we first sent everyone home, with major improvements in our IT tech support and ability to log in remotely, as well as HR initiatives to support staff working at home."

> "We are still working through whether a stipend works or whether we should offer a kit of parts from one of our vendor partners to deliver and install, so that safety is first and foremost. Tracking these assets is by department right now. "

What percentage of your staff will permanently WFH? (best guess, right now)

Percentages of staff expected to permanently WFH after the pandemic run the gamut, from less than 2% to up to 60%, with the bulk of those being call center workers or support services. Most staff who will be hybrid or mostly on site are those whose work is clinical-, education-, or research-focused in nature.

> "We expect a hybrid model with almost all employees in office-based roles working from home at least part of the time."

How do you plan to accommodate WFH employees on site? (touchdown spaces, shared offices, etc.)

Most organizations said they expect more shared workspaces and collaboration rooms, along with some "touchdown" spaces that are department "owned" with a mix of assigned and unassigned seating. This space will include some offices, but mostly cubicles. There will be room for "remote workers" who come into the office for meetings or collaboration with colleagues. Some offices are designating specific "neighborhoods" for departments.

Parking is expected to benefit greatly from this arrangement. Lots that had been overflowing with single-commuting vehicles will now seem spacious and solve the continuous parking shortages that most offices were experiencing pre-pandemic.

> “We are looking at mostly touchdown spaces that are department owned, with a mix of assigned and unassigned seats. Departments want their staff together when on site, so for now, hoteling spaces are dedicated to specific groups.”

> “We will plan unassigned hoteling spaces (some offices, mostly cubicles) for remote workforce staff, as well as planning for additional (or at least ensuring sufficient) collaboration type spaces, such as huddle rooms and small conference rooms.”

How has new thinking around equity, diversity, and inclusion impacted your planning or workspace?

Most academic medical centers say that equity, diversity, and inclusion are priorities already, and that has not changed during the pandemic. There is still an emphasis on these values as WFH assistance is assessed. Managers and HR realize that some homes don’t have access to the best and quickest WiFi or multiple modems or boosters; the ability to buy new computers, monitors, office furnishings, or a separate private room for confidential conversations or HIPPA compliance. Organizations are reaching out to provide employees who need assistance to effectively work from home with the resources that they need or to allow them to safely return to office.

“We have a diverse workforce. Equity, diversity, and inclusion are woven into our core values. I can’t say this has had a big impact on what we are planning for the future of our workplace. We are focused on aligning space and workplace configurations with activity and meeting the functional needs to support the work we do.”

“We reinforce inclusion of needs, for both mental and physical well-being and support across the board.”

DIGGING INTO A HYBRID WORK ENVIRONMENT

For employees whose function could allow them to work part or most of the time from home post-social distancing: Do you anticipate that amount of time will be determined by the employees, their direct manager, the organization’s leadership, or an enterprise-wide policy?

Some medical centers are allowing department heads to make decisions for how their teams will operate, and others have a core workplace strategy team in place making those decisions through surveys and discussions with employees. Broad feedback is required since one solution does not fit all. Decisions that benefit both the employee and the employer are optimal.

“Managers (with input from their staff) and directors have worked with and up through their executive leadership, developing remote workforce plans that best suit the nature of their work.”

“The plan is to work with HR to determine the best approach for our organizational culture and appetite for change. We have used a persona-based approach to help leaders think of mobility in the context of functional needs vs. job title, and to help them determine average- and peak-attendance needs across those determined personas.”

How structured do you anticipate policies around hybrid work will be in your organization: low structure (variety of choices/options) or high structure (specific, enterprise-wide policy)?

For many medical centers, this depends on the department. For instance, patient care areas need to be more highly structured, but for administrative and education areas, there is more flexibility. For research, administrative functions can work more remotely but lab staff will need to be on campus most of the time. For facilities planning, design, and construction, staff will be on campus as needed to address facility needs. In many cases, HR will be called upon to provide structure and guidance. Flexibility, in most cases, will be determined by function.

“Our plan, so far, has been fairly structured from a high-level perspective for setting the base plan and planning for space. But on a day-to-day basis, managers will most likely work with their staff to assess what days of the week and how often their staff members actually need to come on campus, and how productive they are in a remote status.”

> We are seeking to balance some degree of flexibility to create a system that can easily adapt and evolve over time to best support work effectiveness with some degree of structure that will provide the most opportunity for space efficiencies."

Q **What are the perceived long-term benefits of a hybrid work model that most resonate with your employees vs. your leaders?**

- Reduced operational expenses and better attraction/retention (leadership perspective), better work-life balance, reduced commute/travel time, greater flexibility (employee perspective).
- Work/life balance, less use of PTO for staying at home with a sick kid or when you don't feel your best, capture time spent traveling to work to other things, reduced parking and travel to work costs, spend more time with family.
- Work/personal life balance a big win for staff; leaders see more satisfaction and feeling of empowerment of staff with productive outcomes for the most part.
- More time with kids; working in a more relaxed environment (clothing, eating, music, TV, etc.); not having to fight rush-hour traffic; reduced potential exposure to COVID from work colleagues; etc.
- Flexibility and convenience. Time saving for personal life.

Q **Are individual work points in your office-type environments assigned to individuals or shared? Do you expect this may change?**

- Most workspaces are currently allocated to individuals but we are soon to pilot a shared model.
- We have a hybrid of assigned and hoteling, so the proportion of these may change.
- We haven't yet instituted the new remote workforce planning with hoteling space concept, but the original plan is that these spaces will not be assigned to individuals, groups or departments. We'll see how that plays out.
- Assigned to individuals mostly in business settings, clinical setting are share spaces, we do not see that changing except an emphasis on cleaning.
- Office-based moving to shared as the default with possible exceptions based on functional on-site tethered needs.

Q **Hybrid work models require integration between facilities/technology/policies to be successful long-term – have you been working with more or different cross-functional partners than you have before or in novel ways?**

Most medical centers have been working closely with HR and IT to ensure that the institution was prepared for a broad adoption of WFH. The medical side has also had more collaboration with the university side on items like design, architecture, workplace ideas (business college) and safety in the workplace in the face of an infectious disease (public health, epidemiology).

> We have had to be flexible in the use of technology as technology accommodations have evolved. Staff has become more competent in using the tools we have been given for our everyday work. Our division is focused on how we can maintain our culture with remote work and what work practices we need to follow to be efficient, provide quality service, and stay connected."

Q **What are the main differences that you expect to see with regard to adoption of hybrid work long-term, between non-business essential roles (corporate functions) and business essential roles (hospital functions)?**

- My guess is that hospital functions will continue to work on-site, whereas business functions will likely flex between on-site and WFH.
- Many administrative staff will not be returning, or some will only be on campus 1-2 days per week. Employees have figured out how to do their work remotely.
- More flexibility on non-clinical roles for hybrid choices. We are seeing an emphasis of finding spaces for respite/quiet/gym areas to support reducing stress in business essential roles.

- Plans for hybrid remote and primarily remote workforce have been developed up to the executive level across the institution, including clinical, research and administrative functions.
- Space efficiency is a bigger driver on Corporate Function side while new care models and patient volume will be primary driver on Hospital side.

> Because the pandemic has forced remote working for many staff throughout the institution, I think the transition to the new hybrid work model be easier. Many administrative staff will not be returning, or some will only be on campus 1-2 days per week. Employees have figured out how to do their work remotely. Being able to come back to campus on a limited basis, will allow for bring back the personal connection."

FURNITURE/FURNISHINGS

Q **Have you experienced material failures in furniture in the clinical and/or non-clinical arena (from all the cleaning)? If yes, where are the failure points?**

Medical centers represented in the survey are running about 50-50 on experiencing material failures in furnishings. Those that are not experiencing failures say they have made adjustment in cleaning over the years to counteract them.

Q **How do you budget for furniture costs?**

- Historical costs for typical projects or takeoffs from actual test kits.
- New hire/churn, aesthetic renewals, and replacement
- Operational monies for minor repairs/replacement
- Anything over $200K is capital monies (approved once a year so challenging)
- Replacement/repair of furniture for new projects covered by that project's capital budget.

Q **Key factors that drove your furniture solution?**

Cost and related costs, flexibility, ease of reconfiguration, life-cycle expectations, investment in higher-grade furnishings, quality, following set standards, RFP process, serviceability/product warranty, customer satisfaction, ease of use, and maintenance.

> Furniture in healthcare environments is clearly driven primarily by infection prevention and control measures. Of course, cost plays into these decisions as well."

Q What are your space standards today? What are mix of sizes, how are they assigned etc.? Will they be changing?

- We plan office space on a modular approach, where the base module "x" is 6 ft. x 10 ft. Private offices can be 2x or 4x. Touchdown seats are 0.5x. We don't assign space types based on titles, but rather hold a department accountable to adhering to their specific Work Type 1x, 2x, 4x allocations.
- We are going to offer multiple furniture configuration based on activity. We will have limited assigned space remaining to be reservable.
- We have tiered standards for private offices based upon ranking/hierarchy (faculty vs. admin). Working toward space driven by function of role and workplace needs to support that role. This is a huge culture shift.
- We are all over the place with many of our older spaces. As we've planned and built-out spaces in the past 3-4 years, we've tried to plan to more of a standard. Current planning includes:

    - Executive offices – 200 SF
    - Large offices – 160 SF
    - Standard offices – 120 SF
    - Small offices – 80 SF
    - Cubes – 6' x 8'
    - Carrels – 5'

- Generally, we have standards for most room types, such as offices, exam rooms, patient rooms, procedure rooms, etc. We continually look at our standards based on lessons learned but don't intend to make many changes at this time.

> "We are in the middle of a master planning effort and had already planned to make changes in our workspaces. Over the last few years we adopted a kit of parts system for our ambulatory clinic furnishings and were looking to implement that throughout the institution. We are assessing our standards with the new work environment."

Q How much are staff allowed to customize their office/workstation? Are they given options?

- Current standard is fixed, but there seems to be a significant amount of customization for every project. Trying to change that.
- Legacy standard limited to storage and seating options. In process of establishing different work configurations based on activity.
- Limited options within our kit of parts standards. Driven by function and ergonomics.
- Not much. As spaces are renovated, we allow managers/directors to select paint colors from a standard pallet; furniture is standard.
- Some flexibility with configurations and options like adjustable height, storage, etc. However, vendor, colors, etc. are standard and not open for change.

Q How easy is it to swap out furniture from one space to another?

- Not very easy. Furniture reconfiguration for systems furniture is always costly and quite honestly does not seem like it's worth it when the cost of new product is almost the same. Trying to change that.
- Legacy standard—no. New standard is kit of parts—some components are used for both.
- Our kit of parts standards allows for ease of use with freestanding desks and panels that wrap workstations. Looking at height-adjustable desks as a future standard.
- Since we have standardized to a single vendor it is fairly easy to swap whole offices or components or single parts of an office or piece of furniture. That is a benefit of standardizing vendors and having the same systems throughout.

Q How many furniture manufacturers do you use?

- Three to four.
- For desking, two. Various standard manufacturers for other items.
- For office kit of parts furniture, we have two or three; multiple for conference spaces, clinical spaces, waiting areas, etc.
- For the most part, just one.
- For about 85-95% of furniture we use one manufacture. Some small items and accessories we get from other vendors.

TEMPERATURE CHECK

Q

What are your most important priorities/projects right now?

- Furniture standards, transition plan for back to work in September, piloting new workplace environment, refinement of research laboratory metrics, laboratory consolidation to accommodate expansion, expanding our reach beyond the main campus.
- Restacking our administrative buildings, new bed tower, research expansion (new building and vivarium).
- Preventing future damage on new furniture and specifying finish materials, creating new component-based standards for everything outside of our kit of parts office furniture at a negotiated lower price.
- Developing concepts for what's next in the workplace, collaborating with the University, deciding which buildings we lease or own for support/business services should be released, demolished, redesigned.
- Ongoing strategic capital projects and others ready to kickoff that involve heavy planning, programming and concept designs.
- High-level institutional IT initiatives that involve setting up two- to three-year work teams, space planning and renovation, campus-wide plan for new remote workforce, incorporate into overall campus space planning for 2026 personnel projections.
- Office-based work environments for post-social distancing occupancy, untethering and space sharing, decision on real-estate strategy for next five years, charting future of workplace for clinical functions/new virtual care models.

Q

What are the biggest trends that have impacted your workplace over the past year?

- COVID workspace prep and compliance.
- Technology—working remotely, multiple meeting platforms, using multiple devices.
- Health, safety, wellness, quality of work environment.
- More informal space/desire for collaboration.
- Flexible work schedules.
- Importance of EPI and EVS to support a safe environment for all.
- Cleaning and its impact on all finishes/furniture.
- Shift to telehealth for delivery of routine medical advice/care, virtual care models.
- Manager's ability to trust that staff can work from home and be productive/effective.
- Resiliency and teamwork of collective staff.
- Innovation and clearer understanding of how we influence each other's environments and work efforts.
- New thinking and awareness around equity, diversity, and inclusion—leadership embracing and taking charge of culture change.
- Remote workforce planning.
- Digital transformation.

ABOUT EYP

We're an integrated design firm specializing in higher education, government, healthcare, and science & technology.

Disciplines

Architecture, Engineering, Energy, Experiential Graphic Design, Interior Design, Master Planning, Medical Planning

Healthcare Expertise

- Academic Medical Centers Community / Greenfield Hospitals
- Ambulatory & Outpatient Care Inpatient & Outpatient Surgery
- Behavioral Health Inpatient Departments
- Cancer Care Orthopedic Care
- Cardiovascular Spec Hospitals Children's Health
- Critical Care Teaching Hospitals
- Emergency & Trauma Women's Services

Research

EYP seeks out opportunities for research investigations to advance designs that optimize the patient, visitor, and staff experience while maximizing value for owners. As the leader in innovation through evidence-based design, we helped found – and continue to collaborate with – the Center for Health Design (CHD) and the CHD Pebble Project. Our thought leaders continually grow the body of information available to facility users and architects through publications and active participation in organizations including the International Academy for Design and Health, the Society of Critical Care Medicine, and the Robert Wood Johnson Foundation.

eypae.com