HR in the ER

Healthcare Faces the Greatest Workforce Challenge and Underinvested in Talent Management

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Research by:

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WE KNOW HEALTHCARE

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Background

On August 20th, 2015, *HRO Today* magazine and Clinical Magnet, the recruitment process outsourcing (RPO) division of Supplemental Health Care, launched an online study that addressed the perceptions, among Human Resources professionals in hospitals or health systems, of the impact of hospital staffing. Study participants were those either identified through the Question Pro Panel Network as being involved in staffing decisions in hospitals (NAICS 622000) or through a prequalified list of respondents of *HRO Today* magazine subscribers. All participants were screened to confirm they had input on staffing levels and hiring decisions and were employed at hospitals or health systems. In total, there were 75 usable responses on service quality and operations.

Conclusion

Hospitals and health systems have underfunded human resources, which results in lost revenue opportunities. In addition, healthcare C-Suite leadership have asked HR to accomplish nearly impossible tasks in workforce recruitment and retention given the current investments in infrastructure, technology and HR staff levels. This is true in both for-profit and not-for-profit institutions.

While estimates as to occupancy rates vary, it's clear there remains significant opportunity for higher occupancy. Hospital HR staffing professionals contend that the lack of staff to cover demand is a major contributor for not achieving a higher census. This lack of staffing also adversely impacts patient care, and puts added stress on staff, which results in increased turnover. Additionally, wellness programs that have a high ROI often can't be implemented due to staff shortage limitations.

The major factor for the lack of staffing is the inability to find the right people, cited by nearly one- half of study participants.

Key Findings

Opportunity for higher occupancy. While occupancy rates vary greatly across hospitals, only about half of the time the census is above 80%. This suggests there is opportunity for greater occupancy.

The case for more employees. There are myriad reasons why occupancy fluctuates, such as the varying level of demand for beds, cited by nearly two-thirds (64.1%) of study respondents. But the second most commonly cited reason for the census variability is the lack of employees scheduled to cover the beds, cited by 28.1% of respondents.

For nearly one-half (49.3%) of study respondents, demand for more beds than can be accommodated occurs daily or weekly. But that's not because of a lack of beds; rather, it's because of inadequate staffing levels that occur nearly one-half (48.2%) of the time. In fact, nearly two-thirds (62.1%) of study respondents stated their hospitals could have a higher census if there were more employees in patient care.

The single biggest reason for not having enough full-time staff is they can't find the right people to hire, cited by nearly one-half (48.1%) of respondents. The impact on hospital revenue from open beds is enormous. Published estimates show that on average one patient stay amounts to nearly $12,000 for non-profit hospitals and $8,400 in for-profit hospitals.

Wellness programs. Respondents overwhelmingly agreed that more employees would allow them to provide a greater diversity of wellness programs. Wellness programs can be either for employees or patients, but can provide cost savings for employees or a revenue center in patient care.

The average ROI of wellness programs is 53.4%. But the need for qualified staffing for those programs is the major reason more of those programs are not being implemented. Further, one-half (54.0%) of study respondents with wellness programs were very interested in expanding them.

Satisfaction scores. Over three-quarters (78.8%) of respondents agreed that they could achieve higher patient satisfaction scores with additional headcount. Adoption of the HCAHPS makes those scores critical to the long-term operation of the hospital, as scores are easily accessible by potential patients who are able to schedule a hospital stay. Further, The Patient Protection and Affordable Care Act of 2010 includes HCAHPS among the measures to be used to calculate value-based incentive payments.

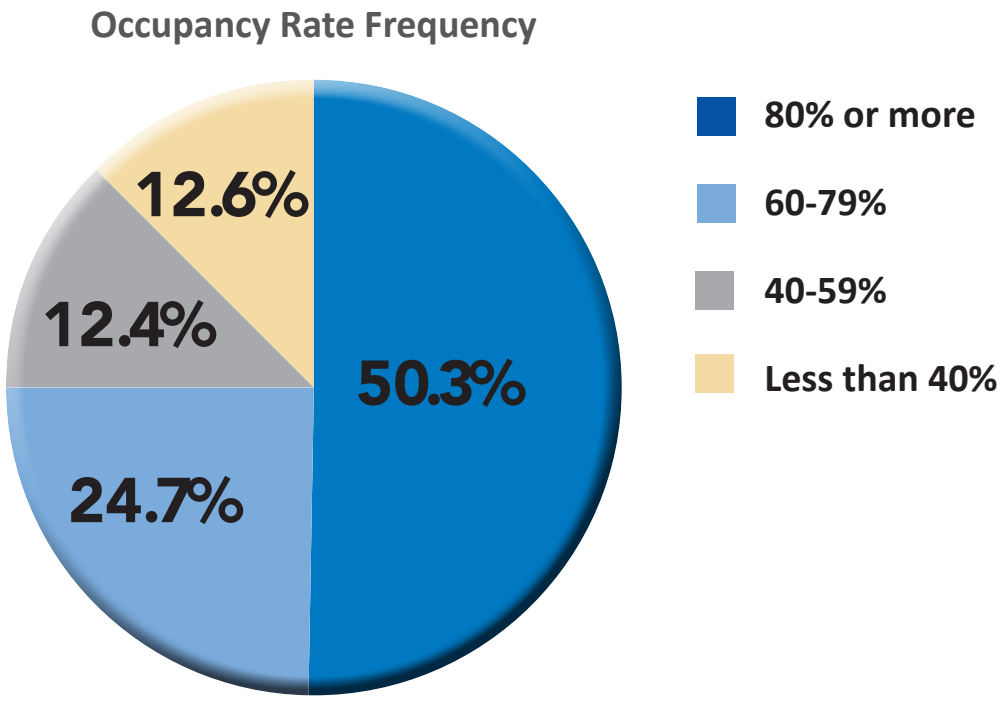
Detailed Findings

Detailed findings from the study are provided in the following pages. Where appropriate, distinctions are made in findings between for-profit, non-profit and hospital capacity. Capacity is defined as the number of beds, and is segmented by those with fewer than 200 and those with 200 or more.

Occupancy Rates

Respondents were asked to provide their occupancy rate percentage by listing the percentage of time they are at each of the occupancy rate ranges provided.

About one-half (50.3%) of the time, the occupancy rate is 80% or more. Low occupancy rates (less than 40%) are fairly uncommon, and occur only 12.6% of the time.

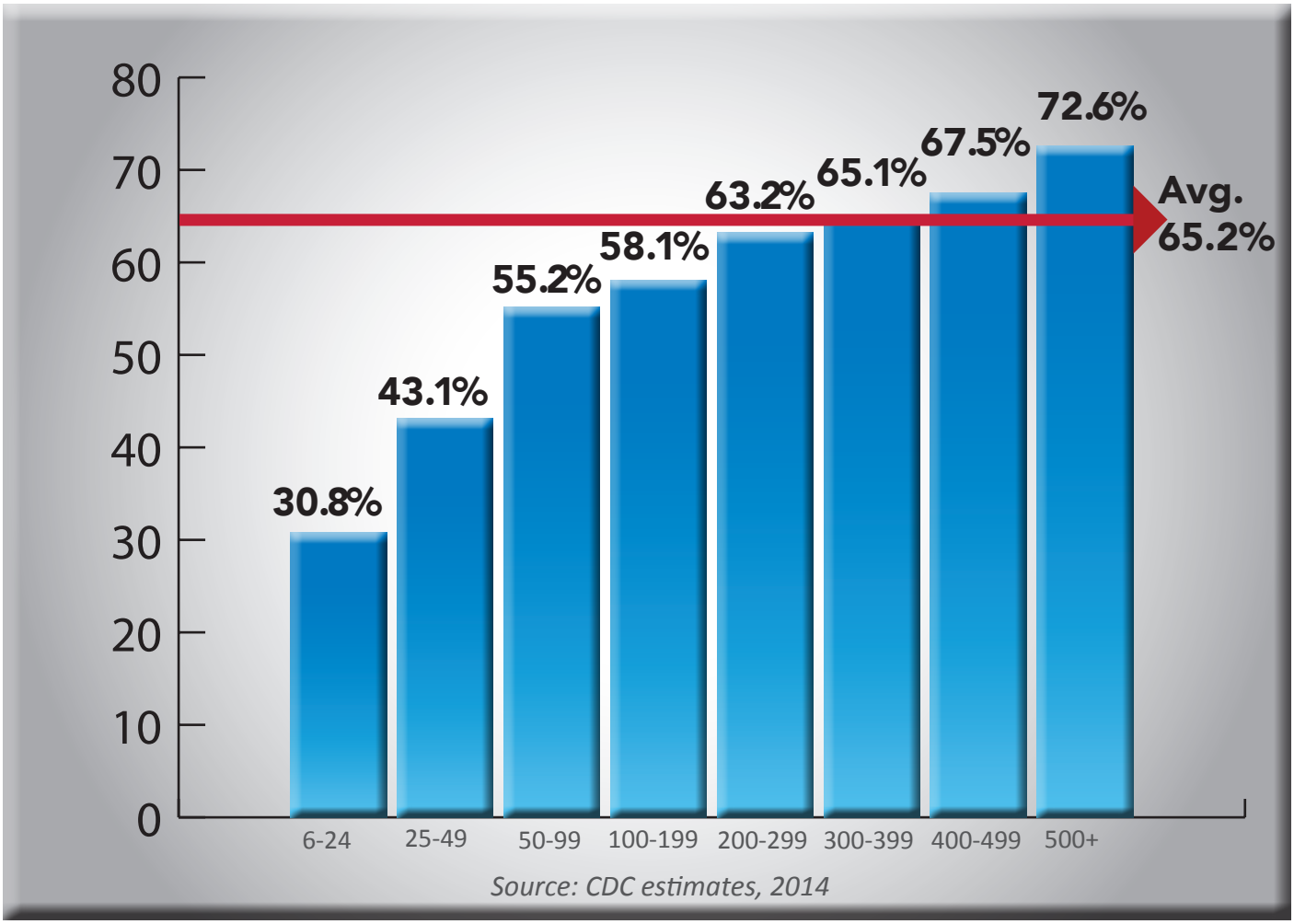


CDC Occupancy Rate Estimates 2014

	2000	2005	2010	2011	2012
Occupancy Rates (All Hospitals)	66.1	69.3	66.6	66.5	65.2

This finding from our study is consistent with averages reported from other sources, though estimates do vary. The most recent data from the US Center for Disease Control (CDC) estimates the average occupancy rate to be 65.2%, with occupancy rates increasing as the number of available beds increases.[i] This data indicates a decline in occupancy since 2005.

US Hospital Occupancy Rates



Clearly, hospitals have a significant opportunity to increase occupancy about one-half of the time, and smaller hospitals (those with less than 200 beds) have the most opportunity. CDC estimates also put non-profit hospitals with a higher occupancy rate in 2012 than for-profit, 64.9% and 56.8%, respectively. This also suggests for-profits have the greater opportunity to increase occupancy.

What is the cause of stagnant-to declining-occupancy over the last several years? Overall, admissions to the nation's hospitals have slumped in the wake of the Great Recession and Affordable Care Act. There's been a change in definition. The federal government's two-midnight rule no longer recognizes admissions for patients with very short hospital visits.[ii] This is due in part to new public policy and marketplace incentives that are encouraging health systems to promote prevention and keep patients with chronic diseases out of the hospital. The shift to outpatient care, underway for decades, is accelerating.

Further, new technology and better drugs also are allowing more patients to receive treatment outside of hospitals. Meanwhile, discretionary surgeries and other procedures are still being postponed since household finances remain stressed, partly because of poor wage growth in the wake of the Great Recession, and partly because more workers are being shifted to high-deductible health insurance plans, which increases household medical bills.[iii]

There is some disagreement about occupancy trends since 2012, the most recent data available from the CDC. Recent major developments in hospital incentives and regulation have produced significant changes in hospital capacity trends. After several years of decline, inpatient volumes and emergency department admissions are on the rise, in part due to the increase in the insured population and Medicaid expansion in certain states. In some cases, providers are reporting misallocation of resources, overwork and potential patient safety hazards resulting from capacity management issues.[iv] There are also increases expected from the 2014 expansion of Medicaid and the introduction of the new mandate to purchase insurance.

But even though U.S. hospitals have reduced the number of available beds from 2006 to 2012, the average hospital occupancy rate still decreased from 64 percent to 61 percent during that same timeframe, according to the Medicare Payment Advisory Commission's March 2014 report.[v] MedPAC said those figures continue to back up the notion that America is overbedded and that "inpatient capacity is expected to remain in excess in most markets."

Reasons for Not Being at or Near 100% Capacity

Hospital HR practitioners were asked to weigh in on why their hospitals were not at capacity. Both for-profit and non-profit respondents agreed that demand for beds fluctuates widely, with significantly more for-profits (74.2%) indicating fluctuating demand than non-profits (54.5%).

Reasons Not at or Near 100% Occupancy

	Total	For-Profit	Non-Profit
Demand for beds fluctuates widely	64.1%	74.2%	54.5%
Not enough employees scheduled to cover beds	28.1%	22.6%	36.4%
Insurance limitations	23.4%	41.9%	9.1%
Limitations of hospital infrastructure	20.3%	25.8%	18.2%
Lack of dedicated talent acquisition professionals	14.1%	12.9%	18.2%
Government regulations	12.5%	16.1%	0.0%
Union regulations	7.8%	6.5%	13.6%
Not applicable	17.2%	12.9%	18.2%
Other	1.6%	3.2%	0.0%

The section below offers additional insight into some of the findings about less than 100% occupancy.

Demand for beds. Seasonal, weekly and even daily patterns emerge to guide staffers in scheduling. But that doesn't mean it's not difficult to schedule staff to meet the fluctuating demand because many don't want to work non-tangential hours, of a more traditional workweek.

Related to the fluctuation in bed demand is the second most cited reason for not being at or near 100% capacity: There is not enough employees scheduled to cover beds, a factor for nearly 3 in 10 (28.1%) of respondents.

Government regulations. There are regulations that dictate the nurse-patient ratio. This impacts the number of patients that can be admitted at any time. The argument for better nurse staffing in the form of more nurses on hand has led to federal and, in some cases, state regulatory requirements. Failure to comply with these requirements can lead to penalties.

The Center for Medicare & Medicaid Services requires Medicare-participating hospitals to have adequate numbers of licensed RNs, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. Although this regulation addresses staffing, it's open to a wide range of interpretations because it doesn't quantify "adequate." Hospitals can demonstrate they met the intent of the law in any way they choose. No indicator or benchmark exists for which all hospitals can claim they're providing adequate nursing care. But research published in the *Journal of the American Medical Association* also says it's not clear exactly how many patients a nurse can care for, but five or six would be wise. California, the only state with a nurse-to-patient ratio law, has nurses caring for five general surgery patients and two in the intensive care unit.[vi]

Insurance limitations. Our study shows that insurance limitations also play a greater role for for-profit hospitals than non-profit, 41.1% vs. 9.1%, respectively. Insurance dictates the length of stay for a patient depending upon the nature of patient treatment, and length of stay greatly impacts staffing considerations. The declining number of days patients stay in the hospital over the last decade has negatively impacted occupancy rates.

Frequency of More Demand for Beds than Can Be Accommodated

The frequency of demand for more beds than can be accommodated varies greatly. For over one-third (34.2%) demand exceeds supply weekly, and for nearly one-half (49.3%) excess demand is either daily or weekly. Non-profits reported weekly demand exceeding supply 57.7%, twice that of for-profit hospitals.

Respondents in the largest hospitals report daily demand exceeding bed supply 20.0% of the time, twice the number of smaller hospitals.

Conversely, 21.9% indicated that they never or almost never have more demand for beds than can be accommodated, indicating a somewhat polarized distribution. This percentage rises to nearly one-third (30.8%) of non-profits and 28.6% of smaller hospitals.

Frequency of More Demand for Beds than Can Be Accommodated

	Total	For-Profit	Non-Profit	<200	200+
Daily	15.1%	28.6%	0.0%	10.7%	20.0%
Weekly	34.2%	25.7%	57.7%	42.9%	34.3%
Monthly	13.7%	17.1%	3.8%	10.7%	14.3%
Quarterly	6.8%	5.7%	0.0%	3.6%	2.9%
Annually	8.2%	5.7%	7.7%	3.6%	11.4%
Never/Almost never	21.9%	17.1%	30.8%	28.6%	17.1%

Reasons for Demand for Beds Exceeding Supply

Study respondents who indicated they did have more demand than could be accommodated were asked when that occurs, and what percentage of the time is it due to staff limitations.

Remarkably, nearly one-half (48.2%) of the time, demand for hospital beds exceeds supply because of staff limitations. Interestingly, smaller hospitals in particular are more inclined to state inadequate staffing levels are the cause more often than larger, 54.2% vs. 45.2%, respectively.

Percentage of Time Demand Exceeds Ability to Accommodate Because of Staff Limitations

	Total	For-Profit	Non-Profit	<200	200+
% Due to Inadequate Staffing Levels	48.2%	47.1%	53.7%	54.2%	45.2%

The impact on patients of having the right staffing levels to meet demand is clear. The number of available nurses is the key to meeting adequate staffing levels. According to *American Nurse Today*, "Better RN staffing levels have been shown to reduce patient mortality, enhance outcomes, and improve nurse satisfaction. One study found that for each additional patient assigned to a given nurse, the patient has a 7% increase in the likelihood of dying within 30 days of admission and a 7% increase of failure to rescue."[vii]

Despite the importance of staffing to meet demand, the study goes on to state that staffing typically is a day-of-operations function in which designated persons assess and determine the shift-to-shift ratio of nurses to patients to ensure adequate staffing on each shift and unit. Typically, staffing processes don't look further than 24 hours in advance of the shift, or 48 hours for a weekend or holiday. [viii]

This suggests that help is needed in rising to the challenge of the complex task of staffing a hospital. The American Nurses Association (ANA), states that no single staffing model—patient acuity, budget-based, or nurse-patient ratio—is best for all settings and situations. Most organizations use a combination of methods and tailor the overall staffing approach to their specific needs. Many nursing specialty organizations have developed position papers or guidelines for staffing and scheduling, which offer more precise ways to determine staffing based on the specific area of expertise than typical budget based or nurse-patient ratios. This uncertainty leads to a staffing dilemma for many hospital-based HR executives.

What are some of the impacts of inadequate staffing levels other than covering the demand for beds? An interesting infographic from the American Nursing Association provides some insight.

Insufficient time with staff, excessively long shifts and fatigue are some of the findings. In short, 33% felt that staffing levels were inadequate to meet patient needs.

Source: http://www.nursingworld.org/nursestaffing[ix]

HR Staffing Considerations

Study participants were asked to state how much they agreed with each statement in a series about staffing considerations. Below are key study findings.

Extent of Agreement with Issues around Staffing Considerations: Percentage that agree or completely agree

	Total	For-Profit	Non-Profit
We could achieve higher patient satisfaction scores with additional headcount.	78.8%	78.0%	80.8%
Our staffing needs are able to be filled by full-time employees at least 75% of the time.	74.2%	85.7%	61.5%
More employees would allow us to provide a greater diversity of wellness programs.	71.2%	82.9%	61.5%
Recruiting staff in the healthcare industry should be flexible because of seasonality in staffing needs.	70.7%	77.1%	68.2%
Recruiting staff in the healthcare industry should be variable because of seasonality in staffing needs.	63.6%	68.6%	61.4%
We could have a higher census if we had more employees in patient care.	62.1%	74.3%	53.8%
Using Workforce Planning/Management outsourcing options results in lost control over the recruiting process.	53.0%	68.6%	30.8%
Travelers are a long term solution to ongoing staffing challenges.	34.8%	40.0%	26.9%

Extent of Agreement with Issues around Staffing Considerations By Number of Beds – Select Comparisons

	<200	200+
We could achieve higher patient satisfaction scores with additional headcount.	75.0%	85.7%
We could have a higher census if we had more employees in patient care.	70.4%	60.0%

Satisfaction scores. Over three-quarters (78.8%) of respondents agreed that they could achieve higher patient satisfaction scores with additional headcount. Larger hospitals in particular were more inclined to agree than smaller hospitals, 85.7% vs. 75.0%. Larger hospitals have a greater fixed cost in facilities and operations, so the incremental cost of more staff can be small compared to the revenue gains from greater occupancy.

Satisfaction scores are very important to hospitals. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. The HCAHPS survey asks discharged patients questions about their recent hospital stay, and focuses on questions about critical aspects of patients' hospital experiences. The Patient Protection and Affordable Care Act of 2010 include HCAHPS among the measures to be used to calculate value-based incentive payments in the Hospital Value-Based Purchasing program. Patients can access these publicly reported results, as CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov).[x]

Need for Full-Time Employees. There is also widespread agreement that respondents feel full-time employees are their best option for meeting needs. Nearly three-quarters (74.2%) felt that staffing needs are able to be filled by full-time employees, while only about one-third (34.8%) felt that travelers are a long term solution to ongoing staffing challenges. On both of these points, for-profit respondents are less likely than non-profits to agree. Specifically, for-profits are more likely than non-profits to agree that staffing needs are able to be filled by full time employees (85.7% vs. 61.5%, respectively, but more inclined to agree that travelers are a long term solution (40.0% vs. 26.9%, respectively).

Travel nursing is a nursing assignment concept that developed in response to the nursing shortage. This industry supplies nurses who travel to work in temporary nursing positions, mostly in hospitals. While travel nursing traditionally refers specifically to the nursing profession, it can also be used as a blanket term to refer to a variety of travel healthcare positions. There are an estimated 25,500 RNs working travel nursing jobs in the U.S., with most travel nursing assignments lasting between 8 and 26 weeks with the majority of positions being offered for 13 week terms.[xi]

Higher census if we had more employees in patient care. Nearly two-thirds stated their hospitals could have a higher census if there were more employees in patient care. For-profit hospitals are nearly 20 percentage points more inclined to agree than non-profit, 74.3% vs. 53.8%. Smaller hospitals are also somewhat more inclined to agree with the statement than larger, 70.4% vs. 60.0%. In the United States, the average cost per day per patient stay in a hospital is $2,214 in non -profit hospitals and $1,747 in for-profit hospitals.[xii] Since the average stay is 4.8 days,[xiii] then the average totals add up substantially – $11,587 for non-profit hospitals and $8,386 per patient in for-profit hospitals. These estimates underscore the need to have high occupancy in hospitals, and the staff needed to support it.

Seasonality. The need for a dynamic recruiting staff to meet seasonal needs was also clear. In fact, 70.7% felt the recruiting staff should be flexible in meeting seasonal needs, while 63.4% felt the recruiting staff should be variable.
Seasonality varies greatly by condition of the patient and location. But generally, admissions are highest in the winter, and lowest in the summer. Findings can segmented by months and days of the week. Two examples of seasonality can be found in looking at examples for cardio-related conditions and for asthma-related admission. [xiv and xv]

Over one half (53%) of respondents also agreed that using workforce planning/management outsourcing options results in lost control over the recruiting process. It's a perception that was particularly prominent among for-profit hospitals; HR professionals agree with the statement more than twice as often as non-profits (68.6% vs. 30.8%, respectively). The challenge for any outsourcing company then has to be how more hiring options can be opened up, and the more day-to-day tasks associated with hiring outsourced, so that those broader deliverables the HR department is tasked with can be focused upon.

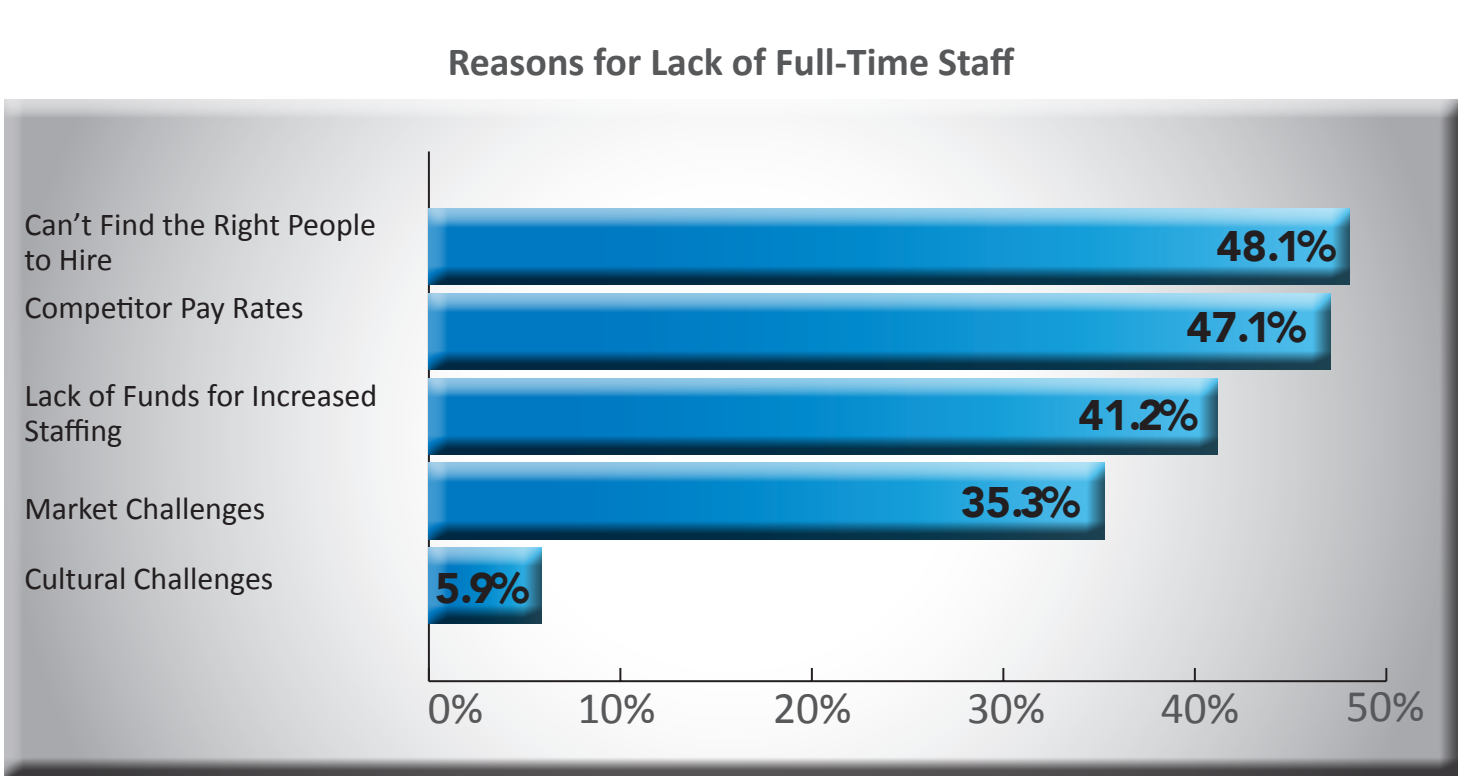
Wellness programs. Another statement with a high proportion of respondents agreeing (71.2%) *is more employees would allow us to provide a greater diversity of wellness programs.* Wellness programs can be either for employees or patients, but can provide cost savings for employees or a revenue center in patient care. Wellness programs and their implications are explored in more detail further in this report.

Reasons for Not Having Enough Full-Time Staff

Study respondents who disagreed with the statement that staffing needs are able to be filled by full-time employees at least 75% of the time were asked what the reasons were they did not have enough full-time staff.

The single biggest reason for not having enough full-time staff is "can't find the right people to hire," cited by nearly one-half (48.1%) of respondents. There has been much written about the nursing shortage, but recent data suggests that RNs have put off retirement throughout the bad economy, and nursing schools have doubled their output of new graduates. Of course these changes do not impact all regions equally, and there is still evidence of struggles to find health care workers in rural areas. "That shortage of care at the bedside tends to be worst in nursing homes, as well as in under-resourced rural facilities where it's hard to attract anyone to work. [xvii]

Closely related to the inability to find the right people to hire are competitor pay rates. Competitor pay rates were cited as a reason for a lack of full-time staff by 47.1% of respondents. The cost, of course, is increasingly relevant as the Affordable Care Act is requiring hospitals to be more efficient with their dollars — which they have historically done by cutting staff, not adding them. Lacking funds for increased staffing is also a budget issue, and part of the definition of finding the right people to hire.

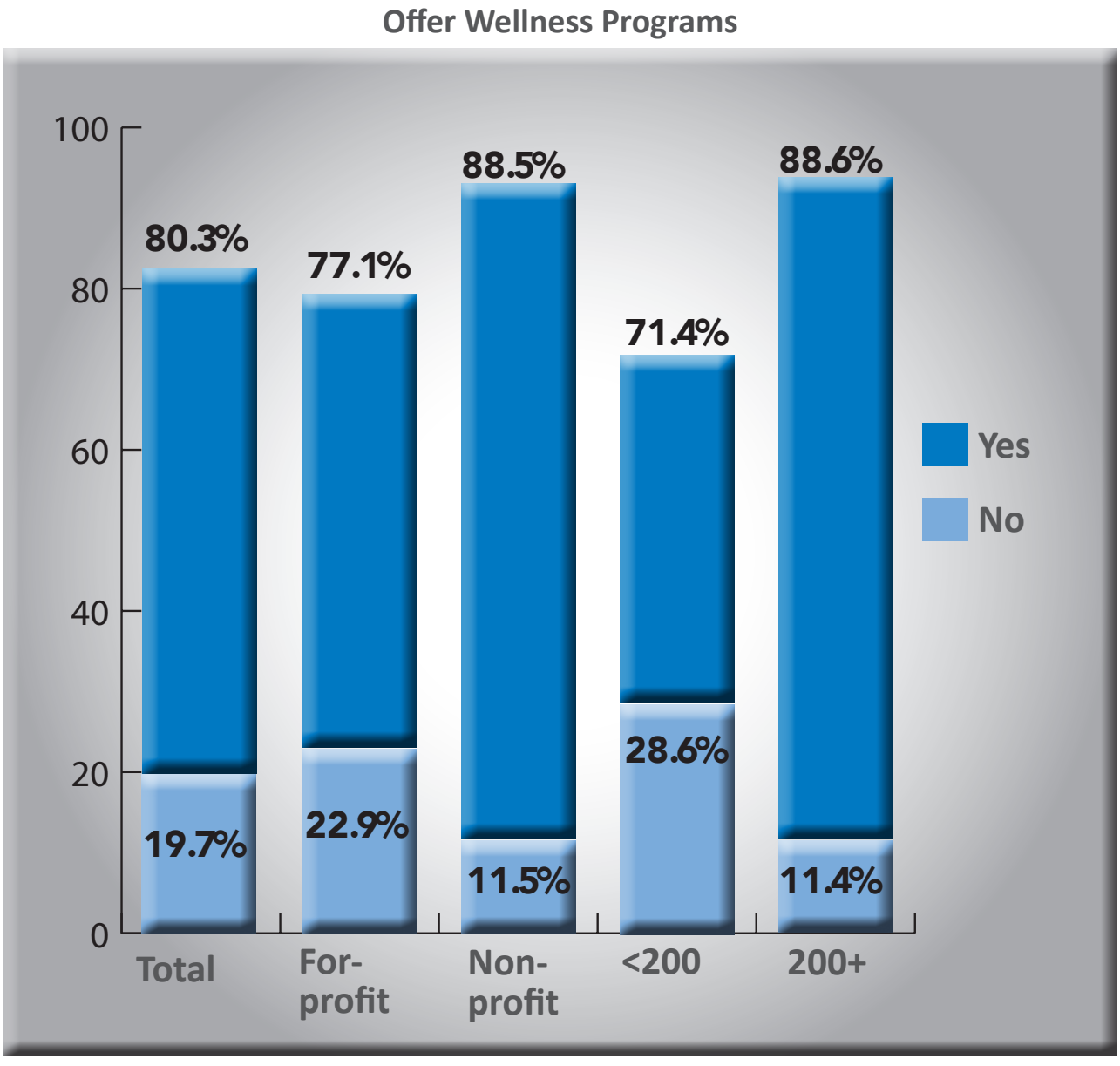


Wellness Programs

As previously discussed, nearly three-quarters (71.2%) of respondents agreed "more employees would allow us to provide a greater diversity of wellness programs." Wellness programs can be both for patients as well as employees. Wellness centers offer assorted programs geared toward creating healthier lifestyles with the medical knowledge and resources of the hospital readily accessible. Examples of wellness programs include Cardiac Rehabilitation, Pulmonary Rehabilitation and Diet and Fitness.

Respondents were asked if they currently offer wellness programs at their facility. A very high percentage, 80.3%, indicated that they did offer the programs. Non-profits and larger hospitals in particular were the groups most inclined to offer wellness programs.

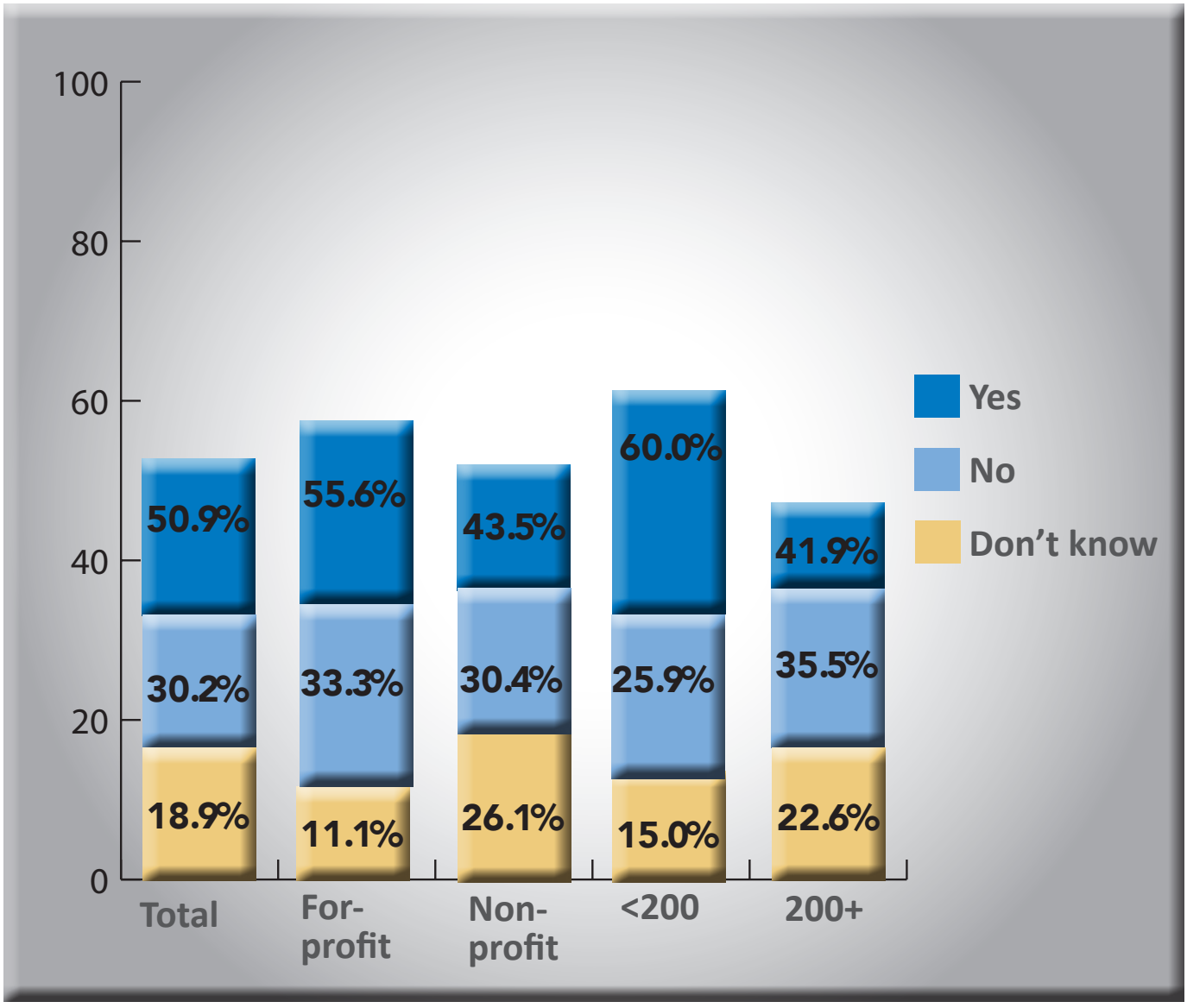
There is support for these findings. According to the American Hospital Association, most hospitals have caught on; a recent survey found that about 86 percent of the nation's hospitals have an employee wellness program of some sort. [xviii]



Incidence of Wellness Programs

Study respondents from hospitals that did offer wellness programs were then asked if they had ever estimated the ROI (Return on Investment) of wellness programs. Only about one-half (50.9%) have ever estimated the ROI of the programs, with nearly 1 in 5 (18.9%) not aware if such an estimate had ever been done.

Estimated ROI of Wellness Programs



ROI of Wellness Programs

In our study, the ROI percentage was asked among those who indicated they had calculated the ROI of their wellness programs.

ROI Percentage

	Total	For-Profit	Non-Profit	<200	200+
Average ROI	53.4%	59.2%	49.1%	62.3%	48.5%

Not every hospital is measuring their return on investment, or ROI. But the American Hospital Association notes that 82 percent of those that do measure it have found that it equals or exceeds their expectation.

In the *Healthcare News* article "The ROI of Hospital Employee Wellness Programs, "LuAnn Heinen, vice president of the National Business Group on Health, said, "There is an ROI when you really do it. There's a really, really good ROI."

Heinen cited a 2011 Health Affairs study, which found that well-designed workplace wellness programs averaged a 3:1 return on investment. The study noted that medical costs tend to fall by $3.27 for every dollar that's spent on wellness programs—and absenteeism costs tend to fall by $2.72 for every dollar spent. [xix]

An article in the *Harvard Business Review* demonstrated how ROI can be attained through employee wellness programs. Focusing on one employer, doctors Richard Milani and Carl Lavie studied a random sample of 185 workers and their spouses. The participants were not heart patients, but they received cardiac rehabilitation and exercise training from a team of experts.

Of those classified as high risk when the study started (according to body fat, blood pressure, anxiety level and other measures), 57 percent were converted to low-risk status by the end of the six-month program. Furthermore, medical claim costs declined by $1,421 per participant, compared with those from the previous year. A control group showed no such improvements. The bottom line: Every dollar invested in the intervention yielded $6 in healthcare savings.[xx]

But positive ROI calculations are not accepted by all. An article from the *New York Times* stated, "What research exists on wellness programs does not support this optimism. This is, in part, because most studies of wellness programs are of poor quality, using weak methods that suggest that wellness programs are associated with lower savings, but don't prove causation. Or they consider only short-term effects that aren't likely to be sustained. Many such studies are written by the wellness industry itself. More rigorous studies tend to find that wellness programs don't save money and, with few exceptions, do not appreciably improve health. This is often because additional health screenings built into the programs encourage overuse of unnecessary care, pushing spending higher without improving health.[xxi]

Hospitals and other medical facilities play a unique role in the community. The mission, influence and reach of hospitals make them champions for worksite wellness and community-wide health promotion. An article from the American Hospital Association states, "Hospitals and health systems and their employees are critical place in their communities because of their leadership and mission. It is paramount for hospital and health system employees to lead the way and serve as role models for healthy living and fitness for their communities. Hospital health and wellness strategies and tactics are crucial to providing the environment, resources, programs, and incentives for hospital employees to serve as such role models." [xxii]

Factors that Limit Wellness Programs

Respondents were asked what, if anything, limits the number or scope of the programs offered. Once again, staffing considerations were the foremost consideration. The need for qualified staff is the largest factor that limits wellness programs, and was cited by over one-half (54.0%) of study respondents. Non-profits cited the need for qualified staff more than for-profit organizations, 63.6% vs. 48.1%, respectively.

Another staffing consideration is the need for adequate staffing levels. Nearly one-half (48.0%) cited this factor as also limiting the number of scope of wellness programs offered.

Factors that Limit Wellness Programs

	Total	For-Profit	Non-Profit
The need for qualified staff	54.0%	48.1%	63.6%
The need for adequate staffing levels	48.0%	47.1%	50.0%
Limited demand	32.0%	25.9%	40.9%
Capacity of facility	28.0%	33.3%	22.7%
Insurance regulations	24.0%	33.3%	9.1%

Interest in Expanding Wellness Programs

Those respondents with programs were asked how interested they are in expanding the wellness programs they offer.

Nearly 9 in 10 (86.0%) respondents were interested in expanding their wellness programs. In fact, over one-half (54%) were very interested in expanding the programs they had, suggesting high satisfaction with the outcomes they had achieved. For-profit medical institutions had the most interest in the programs, with 70.4% very interested in expanding them, nearly twice that of non-profits (36.4%).

Interest in Expanding Wellness Programs

	Total	For-Profit	Non-Profit
Very interested	54.0%	70.4%	36.4%
Moderately interested	32.0%	25.9%	36.4%
Slightly interested	8.0%	3.7%	13.6%
No interest at all	6.0%	0.0%	13.6%

Wellness Programs Considered but— not Implemented

Study participants whose health organizations have wellness programs were asked to state the programs they considered but did not implement.

While responses varied, the largest type of program was around physical activity; Gym/Exercise/Yoga. Some of these comments alluded to the installation of a fitness facility on location while others were about a gym reimbursement program.

One respondent offered more detail into what had been discussed. "Alternative, Complementary & Preventive Awareness programs for common cancers like Breast, Prostate, Colon & Lung."

Wellness Programs Considered But Not Implemented

	Total
Gym/Exercise/Yoga	35.7%
Dieting	10.7%
Smoking cessation	10.7%
Children's issues	7.1%
Other*	35.7%

*Other programs include: Cardio, sleep, substance abuse, mental health

Reasons for Not Offering Wellness Programs

Study respondents who did not currently offer wellness programs at their facility were asked to state what prevented them from doing so. The most commonly stated reason was cost, as 36.4% offered comments around their perceptions of the cost in setting up and maintaining the program. Staffing limitations was the only other response that more than 10% of respondents cited.

Reasons for Not Offering a Wellness Program

	Total
Cost	36.4%
Staffing limitations	18.2%
Lack of employee interest	9.1%
Company culture	9.1%
ROI concerns	9.1%
Other	18.2%

Programs and Operational Changes with Increased Staffing

Study participants were asked to describe the the types of programs or operational changes your hospital could make if they had increased staffing.

There were nearly 60 responses about the types of programs or operational changes a hospital could make with increased staffing.

Most of the comments could be classified in one of four ways: higher occupancy, increased patient care, increased services and programs, and reduced staff fatigue and turnover.

Comments around higher occupancy

- Better staffing for increased bed capacity
- If we had increased staffing, we could admit so many more people. We could operate faster, have faster service and better patient care
- Increase census and offer disease-specific training.
- Increase numbers in our facility. Like to have several social workers on staff. Also a behavioral specialist to help out.
- Could take on more beds

Comments around better care

- Better patient care and more focus on quality.
- Better service, quicker discharges.
- Cut waiting times and improve patient care and staff well-being.
- Decrease in medication errors. Less burnout for nurses. Quality of care to patients would increase.
- Higher patient satisfaction and quicker response to patient needs.
- I feel we could better serve our patients such as doing more things for them and answering call lights faster. Being able to offer more activities if there are enough staff to run them.
- The biggest change that would take place if this healthcare system could increase staffing would involve an increase in efficiency and enhancing the value of the healthcare provided to the patient.
- Safety issues with consumers could be addressed

Comments around more programs or services

- Could have more hand-on programs for patients if numbers and productivity were not such big issues. No time for one on one care.
- Currently, we have to send patients to our nearest large city hospital for more complicated procedures or procedures that we don't have nurses or doctors educated to perform. Most other rural hospitals do not have this problem. We lack critical care nurses and nurses with all specialties.
- We could offer a gym, and nutritional counseling.
- I'd love to implement more rehabilitation and physical therapies within our location instead of sending them to other facilities.
- Increased sleep program. Focused on obesity and weight loss health. Reach out to juveniles who suffer with mental illness.
- We could provide more programs dedicated towards patient satisfaction.
- We will establish nurse visiting patient at home program.
- More pharmacists free to do discharge counselling, wellness education, and clinical calculations for medication safety purposes. More nurses freed up to perform wellness education and oversee discharge planning more

closely, and quality improvements in many arenas.
- Increased sleep program. Focused on obesity and weight loss health. Reach out to juveniles who suffer with mental illness.

Other

- Increase the coverage in ED for traumas during seasonal highs in cases; cut back on rotating shifts to allow for more stable work schedules thereby reducing fatigue.
- Increased automation.
- My staff could have more family time my patients would not feel rushed in their treatment.
- They could change working hours because the 12 hour shifts are too long for employees and this could result in employee fatigue. The hospital has the capacity to open more wards.
- We could be more proactive in recruiting efforts.

Demographics

	Total
Hospital Type	
For-profit	55.6%
Non-profit	41.3%
Government-owned	3.2%
Other*	35.7%
Number of Beds in Facility	
Fewer than 50 beds	12.7%
50-99 beds	6.3%
100-199 beds	25.4%
200-299 beds	11.1%
300-399 beds	15.9%
400-499 beds	15.9%
500 beds or more	12.7%
Hospital Setting	
Rural	20.3%
Urban	68.8%
Other	10.9%
Location	
Northeastern (CT, DC, DE, MA, MD, NH, NJ, NY, PA, RI, ME, VT)	23.8%
Southeastern (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV)	30.2%
Southwestern (AZ, NM, OK, TX)	7.9%
Middle Western (IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD, WI)	22.2%
Western States (CO, ID, MT, NV, UT, WY)	5.7%
Pacific (AK, CA, HI, OR, WA)	7.9%
Canada	0.0%
Outside the United States or Canada	2.2%

End Notes

i Table 98. Hospitals, beds, and occupancy rates, by type of ownership and size of hospital: United States, selected years 1975–2012, CDC 2014.

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xi Travel Nurse Insights: Barry W. Padgett 1st Edition 2009.

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xviii American Hospital Association

xix The ROI of Hospital Employee Wellness Programs, Jennifer Larson, *Healthcare news*, 2011 http://www.amnhealthcare.com/the-roi-of-hospital-employee-wellness-programs/

xx Leonard L. BerryAnn M. MirabitoWilliam B. Baun What's the Hard Return on Employee Wellness Programs? *Harvard Business Review* Decemeber 2010 https://hbr.org/2010/12/whats-the-hard-return-on-employee-wellness-programs

xxi *NY Times* Do Workplace Wellness Programs Work? Usually Not. September 11, 2014 http://www.nytimes.com/2014/09/12/upshot/do-workplace-wellness-programs-work-usually-not.html

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