Evidence Based Design Virtual Roundtable Transcript

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00:00:05.177 --> 00:00:19.627
Jennifer Youssef: Hello, hello, everyone, and welcome to today's webinar this virtual roundtable discussion between arson agent health on evidence-based design. I'm Jennifer Youssef, and I'm delighted to be your moderator. For this engaging conversation

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00:00:19.807 --> 00:00:25.317
Jennifer Youssef: with over 20 years dedicated to healthcare architecture. I've had the privilege of witnessing a lot of changes.

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00:00:25.397 --> 00:00:37.966
Jennifer Youssef: and not a lot of changes in this field. First hand. As a vice president of healthcare here at RS&H. I've had the honor of contributing to transformative projects that help continue to define the healthcare landscape.

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00:00:38.077 --> 00:00:44.647
Jennifer Youssef: I'm deeply passionate about our industry, and I believe the spaces we create impact, patient well-being, and recovery.

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00:00:44.737 --> 00:00:50.977
Jennifer Youssef: So I'm excited to guide this conversation alongside with my associates and our client at advent health

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00:00:51.365 --> 00:00:54.757
Jennifer Youssef: as we delve deeper into the topic of evidence-based design.

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00:00:54.987 --> 00:00:56.887
Jennifer Youssef: Now I'm going to kick it over to you, Mike.

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00:00:57.427 --> 00:01:06.889
Michael Compton: Thank you, Jennifer. Hello, everybody! And for those who I don't know I am a recovering architect. I now work for Advent health

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00:01:08.132 --> 00:01:13.147
Michael Compton: managing construction and capital improvement projects as you can see from my

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00:01:13.187 --> 00:01:18.956
Michael Compton: my picture in the in the alphabet soup after my name. I am also deeply interested in

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00:01:19.411 --> 00:01:29.482
Michael Compton: evidence based design. I am board, certified healthcare Architect. I'm also lead sorry, Edac accredited and lead. I left those those numbers off there, or letters off there, too.

12
00:01:30.159 --> 00:01:39.854
Michael Compton: I also have been in doing this for over 20 years, and and and feel like we have a a large opportunity in front of us to move the needle towards

13
00:01:40.849 --> 00:01:41.914
Michael Compton: more evidence,

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00:01:42.877 --> 00:01:48.037
Michael Compton: and producing evidence. And I think that's one of the things that we can do on the owners side is help.

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00:01:48.793 --> 00:01:58.446
Michael Compton: Provide an environment for the that evidence to occur. I've been a consumer for a long time. I've participated in in peer reviewed articles.

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00:01:59.046 --> 00:02:05.846
Michael Compton: And I'm anxious, very anxious, actually, to to move this needle forward is desperately needed.

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00:02:06.204 --> 00:02:14.467
Michael Compton: I honestly forgot Jennifer, who I'm supposed to kick it off to. So I'm gonna take a guess at Steven. So alright, Steven, thank you.

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00:02:14.467 --> 00:02:24.367
Stephen Szutenbach: Yes, thanks, Mike. Hi, everyone. I'm Steven Szutenbach. I am also recovering architect. I I am a senior project manager here at admin health

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00:02:25.281 --> 00:02:34.357
Stephen Szutenbach: and also have some alphabet soup behind my name. I'm likes to register architect lead Bd plus C. Also well certified.

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00:02:35.009 --> 00:02:52.807
Stephen Szutenbach: And and I, too, have have a great passion for both design and architecture, but also primarily in my career, has been almost 100% focused in in the health, health space, and and and caring for people. And so really, at the end of the day, what's most important to me, and and and understanding how.

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00:02:53.363 --> 00:02:59.887
Stephen Szutenbach: Any process, whether it's evidence based design or anything else, can improve the lives of the people that we serve.

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00:02:59.937 --> 00:03:11.416
Stephen Szutenbach: And so we have. We've done that. And we're working to continue to do that better. Through multiple processes, including evidence based design. So I think I pass it off to Jessica next.

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00:03:11.417 --> 00:03:40.856
Jessica Whitlock: Yes, yes, thank you, Steven. Hello! My name is Jessica Whitlock. I am an associate vice president here at Rs. And H. I also have a little bit of alphabet soup after my name as well. I'm registered into your designer. I'm also very proud to be a a board certified. healthcare interior designer as well. I have over 1213 years experience and all that is in healthcare. I basically, you know, 13 years ago

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00:03:40.857 --> 00:03:45.337
Jessica Whitlock: had a chance to start healthcare, and I never looked back. Absolutely love it.

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00:03:45.647 --> 00:04:12.626
Jessica Whitlock: I'm excited to expand our journey more into evidence based design, and really being able to gather the data and really use it to our advantage. And how do we use that to our advantage. To successfully be able to see some of those changes within our projects as we move forward. And how do we take a closer look at evidence based design and how that can impact our future our future spaces for our patients. So I'll kick it off to Victoria.

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00:04:13.007 --> 00:04:37.496
Victoria Villarreal (RS&H): Awesome. Thank you. I am working on my alphabet soup. We will get. I graduated from Texas A. And M with a specialty and health systems and design. After graduation came to Houston, and I've had the opportunity to work with some really incredible clients and some really great projects. And learning what value we can bring our clients is, I think, one of the most fascinating things about evidence based design.

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00:04:37.627 --> 00:04:43.227
Victoria Villarreal (RS&H): Right? So with that being said, I think I can go ahead and kick off into our introduction portion.

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00:04:44.647 --> 00:04:53.866
Victoria Villarreal (RS&H): Alright, here we go. So before we begin the moderated portion, we're gonna talk a little bit about evidence based design and the foundational elements.

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00:04:53.867 --> 00:05:20.126
Victoria Villarreal (RS&H): So let's kick it off by talking about this phrase. Right? Evidence based design. This term carries a lot of connotations. We think of words like rigor data. It has a very white coat, rigid lens, if you will, and we hear this phrase in a variety of applications, projects, some of which can seem unattainable, depending on your firm, the resources, and sometimes even the willingness of our clients.

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00:05:20.227 --> 00:05:36.946
Victoria Villarreal (RS&H): But we're here today to really pull the curtain back and have a more relaxed conversation regarding the value of evidence based design, which at the end of the day is really all about supporting our clients and helping them make decisions that we hope will yield the best possible outcomes for everybody involved.

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00:05:38.607 --> 00:05:58.976
Victoria Villarreal (RS&H): Alright. So why do we approach design in this way, or or why would you approach design in this way? Right? At the core of evidence based design is this link between research and design and the Ed. Volume 2 book which I reference, I will reference a couple of times. Has a really great graphic comparing evidence based design and evidence based medicine.

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00:05:59.167 --> 00:06:22.267
Victoria Villarreal (RS&H): Now, evidence based medicine definitely yields. Has a more systematic approach to the practice of medicine, and this is done by means of research and evaluation. Now, while evidence based medicine is more of a quantitative approach, evidence based design offers a really unique opportunity. To look at both the quantitative and qualitative data.

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00:06:22.567 --> 00:06:37.967
Victoria Villarreal (RS&H): Now, evidence based medicine will, I think, always yield a higher level of rigor just because medicine has a longer history, a larger wealth of empirical data. From clinical trials and data analysis is

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00:06:38.267 --> 00:06:52.066
Victoria Villarreal (RS&H): but from the design side we do have a growing body of rigorous study and a lot of room for improvement as the design community continues to implement and share their evidence-based design goals and results.

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00:06:53.047 --> 00:07:22.057
Victoria Villarreal (RS&H): So, moving forward, diving a little bit deeper into the actual process of evidence based design. We like to highlight that evidence based design is not a linear process. It is really a fluid and dynamic. It was organized for different applications, clients and goals and the center for health highlights. The 8 step process, beginning with organizational readiness, pre-design construction and then occupancy.

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00:07:22.137 --> 00:07:36.867
Victoria Villarreal (RS&H): It's really important to note that maybe not all parts of the wheel are relevant or pertinent to your project right, maybe steps of 4 through 8 r, it really just depends on the project data and conditions of your project.

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00:07:37.087 --> 00:07:42.917
Victoria Villarreal (RS&H): Today, we're going to do a little bit of a deeper dive into the focus design portion of this wheel.

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00:07:43.537 --> 00:07:47.486
Victoria Villarreal (RS&H): And we're going to start that by looking at methodologies.

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00:07:47.687 --> 00:08:07.097
Victoria Villarreal (RS&H): So I like to begin with an understanding of methodologies. Just because methodology is the, it's the set of guiding principles for your study. It's gonna help underline what it is that you're looking to achieve evidence. Based design consists of 3 different methodologies. We have quantitative, qualitative and mixed methods.

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00:08:07.357 --> 00:08:37.206
Victoria Villarreal (RS&H): When we take a look at the quantitative data, we're looking at systematic investigations of tangible facts. Right? This type of research allows you to objectively measure data of interest. When you're using this, you're more interested in norms and averages as opposed to personal preferences or individual performances. A good example of this would be noise levels in a nursing unit measured by a sound meter or a patient's length of stay.

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00:08:38.327 --> 00:08:51.596
Victoria Villarreal (RS&H): Now I'm gonna look at the qualitative. The qualitative approach is definitely has a shorter life than the quantitative. It's only been used probably about 50 years. Starting in the social sciences.

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00:08:52.481 --> 00:09:11.767
Victoria Villarreal (RS&H): But the qualitative approach emphasizes multiple participant views, perspectives and theory generation. We're

definitely more focused on experiences and interactions. And it is definitely more open minded. It's more flexible in terms of procedure, design and measurement methods.

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00:09:12.107 --> 00:09:35.567
Victoria Villarreal (RS&H): And lastly, there is the mixed methods which mythmic, sorry, mixed message, mixed methods is a combination of quantitative and qualitative and when you're able to combine these various methods they tend to supplement and counter balance from one another, causing triangulation, which is great. We want as much validity in our studies as we can get.

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00:09:37.087 --> 00:10:01.457
Victoria Villarreal (RS&H): And moving forward, we can take a look at research design. So how you organize your research design is is unique to each project. And with that being said, a well designed research study can effectively address the research questions and provide solid, solid evidence in supporting our clients. It's really crucial to understand most important questions to ask, and what type of data you would like to yield.

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00:10:01.727 --> 00:10:18.586
Victoria Villarreal (RS&H): And I've got a list of some examples from the Edac volume to book. But one example is, you know, the just in time theory. If you've got a time sensitive project, things need to be turned around quickly. You may decide to look at the just in time, as it will yield results quicker

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00:10:20.047 --> 00:10:43.083
Victoria Villarreal (RS&H): and moving forward. Once we understand how to organize our research, we can take a look at the different data collection measurement tools, and I do strongly advocate for at least one member of your team to have an ed certification. It just provides a really great sense of foundational knowledge and vocabulary pertinent to utilizing this process.

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00:10:43.707 --> 00:10:55.076
Victoria Villarreal (RS&H): but measurement tools are focused on the process of data collection. When we talk about data collection, it is important to consider validity and reliability

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00:10:55.700 --> 00:11:19.486

Victoria Villarreal (RS&H): reliability, meaning that the degree to which a measurement tool produces a consistent or similar results at different times, or used by different people. And really it all depends on on your project. Right? There's a variety of different applications again, noted from Edac volume to observation. Questionnaire. There are many more. These are just a couple of them that are listed.

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00:11:19.487 --> 00:11:41.167
Victoria Villarreal (RS&H): And when talking about measurement tools. I also like to highlight that there are formatting factors to consider right? Perhaps the delivery of the project is better. In digital right, depending on the budget. Maybe it's better to deliver some of these in paper or in person, if you want to have an additional observation factor associated with it.

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00:11:43.907 --> 00:11:51.636
Victoria Villarreal (RS&H): Now we've discussed methodologies, research, design and data collection tools. Next, I want us to take a look at metrics.

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00:11:51.727 --> 00:12:12.236
Victoria Villarreal (RS&H): A good goal is measurable, and in order to be measurable, we need metrics, and I always get asked, how do you decide? You know what you want to measure or what you want to focus on. And I always say these conversations should be really organic and be with your client specific talking about the project goals

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00:12:12.237 --> 00:12:26.506
Victoria Villarreal (RS&H): right? And then staying up to date with available data as well as case studies. Architects have a unique opportunity to bring this knowledge and value to our clients and discussing design opportunities that are trackable and measurable.

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00:12:26.507 --> 00:12:45.367
Victoria Villarreal (RS&H): And I always say most important thing is to start small right? We, we get into these design projects, and we see a variety of things that we could fix sometimes focusing on one thing at a time and really trying to evaluate the improvement of that metric. Is better than taking on more than you can chew.

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00:12:47.047 --> 00:12:54.197

Victoria Villarreal (RS&H): and at the end of the day it is about our clients, right what their goals are, and making sure we're all on the same page.

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00:12:55.387 --> 00:13:15.387
Victoria Villarreal (RS&H): So we may not always yield positive results. And I say that because we make these assumptions and assessments, and we hope to yield something positive. But those results are not always what we expect, and there is absolute value in understanding the variables and metrics associated with said results.

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00:13:15.708 --> 00:13:26.645
Victoria Villarreal (RS&H): When we share data, we grow as a design community. And when we get to know our own personal knowledge, I feel like we can expand the value that we're providing to our clients.

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00:13:27.309 --> 00:13:47.156
Victoria Villarreal (RS&H): one of the most important outcomes of evidence based design is a commitment to observing the results of our design, sometimes great, sometimes not so great. And with that being said, I'm gonna go ahead and tee this over to Jessica to talk a little bit about a project where we've implemented some of these concepts.

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00:13:47.507 --> 00:14:10.966
Jessica Whitlock: Thank you, Victoria. So I know we did. A high level overview of evidence based design and some of the metrics behind it. So thank you, Victoria, for that. And right after my section, we're gonna go right into our roundtable to really start asking some of those really important questions and have really, you know, meaningful conversations around Evan space design and some of those barriers that we face and

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00:14:11.263 --> 00:14:35.576
Jessica Whitlock: really taking a closer lens. So I know I am. I'm the one that's keeping you from the roundtable. So I'm gonna try to speak briefly, so we can allow as much time as we can for discussions which I know is probably the biggest thing that everyone is here for. So for those of you who had the opportunity to go to Hcd. Last fall. Our team had the privilege to speak at Hcd. This year in regards to evidence-based design.

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00:14:35.903 --> 00:14:52.210

Jessica Whitlock: And this webinar is kind of a spin off from that presentation that we did at Hcd. And while we're a at Hcd, we were able to dive really deep into 2 case studies that we did with advent health at the altimet campus. One of them being

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00:14:52.537 --> 00:15:15.706
Jessica Whitlock: our miu project that you see here on the screen. And so I wanna kind of give just a high level overview of some of the things that we were able to do in this project. If you want more information, though, on some of the details or some other information that we may have gotten into on a deeper level when we're at Hcd. Please feel free to reach out to me. You can reach out to me on Linkedin or email me, and I'm happy to share that information to you.

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00:15:16.207 --> 00:15:41.187
Jessica Whitlock: So for the mother infant unit, we approach this more from a qualitative metric for this project. And we I wanna remind everyone that you know, I know there's a qualitative and a quantitative metric when it comes up in space design. But a lot of our qualitative data then feeds the quantitative data like Hcap scores, they have connection to each other. So we need to remember that when we're trying to do research

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00:15:41.187 --> 00:15:56.418
Jessica Whitlock: trying to gather data, whether it's broad or project specific or even unit specific is a lot of that. Qualitative data can then result into quantitative. And I believe that's what's really gonna happen here at the mother infant unit. We were able to

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00:15:56.757 --> 00:16:21.696
Jessica Whitlock: take basically an existing patient floor that had about 26 rooms. And and there were small tight rooms from the 19 seventies and be able to convert to the rooms to make one larger room, which is the rendering you see here on the screen. And we did that for about 10 rooms, and we converted them to 5 larger rooms. So we took 10 small rooms and

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00:16:21.697 --> 00:16:35.496
Jessica Whitlock: converted them to 5 larger rooms to be able to give a better, a patient experience and a more updated you know, level of care that they already expect from having help, but being able to actually put it within the facility as well.

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00:16:35.918 --> 00:16:38.896
Jessica Whitlock: So with that we were able to create a

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00:16:39.317 --> 00:17:08.267
Jessica Whitlock: 3D mock up of this patient room for our clinical team, where we actually constructed it with our construction partner, Bassfield and Gory, where they were able to completely mock it up, and we were able to then, create surveys and gather information from the clinical team to be able to make sure that we're designing everything to the information we already had on. What is, you know, best practice versus or

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00:17:08.267 --> 00:17:32.296
Jessica Whitlock: in in junction? 2. Getting what is really working well for their operational team, and we had a series of different meetings where we brought in different groups and different physicians and nurses and the executive team, and we had color coded posts where everyone was able to provide their feedback and attention on every single detail of this patient room over a series about 2 weeks.

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00:17:32.297 --> 00:17:51.216
Jessica Whitlock: We took that data and put it into a complete presentation for the Admin help team to be able to let them know these are things that we're seeing. And here's how we're gonna adjust the design to make sure we're really responding well to the clinical team and also providing something to them that we know is gonna work towards their Hcf scores.

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00:17:51.649 --> 00:18:16.217
Jessica Whitlock: In addition to that, we also did something similar with their furniture. We had a huge furniture bear where we created surveys, and we brought in multiple pieces of furniture. The clinical team, the Evs team, the executive team. Everyone came through to be able to provide thought and input on those pieces of the furniture. So we know that we could gather that information and be able to take it to the executive team and say, Okay, here are the top pieces.

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00:18:16.217 --> 00:18:25.766
Jessica Whitlock: Here's why. And this is going to be our recommendation for best choice, based off of this exercise and survey that we were able to put together from a qualitative perspective.

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00:18:26.125 --> 00:18:49.817

Jessica Whitlock: So it was a really great exercise be able to put into place, and we also were able to highlight that during our seminar Hcd, where we're talking about a small practice approach to kicking off evidence based design and how we're implementing that in some of our projects today. So with that, said, I'm gonna go ahead and kick off our Round table discussion. So we can start getting down and dirty into our conversations around Evan. Space design.

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00:18:53.887 --> 00:18:55.367
Jessica Whitlock: Welcome back right.

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00:18:55.517 --> 00:19:00.216
Jennifer Youssef: Yes, so I'm gonna kick it off to you first, Stephen.

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00:19:00.217 --> 00:19:00.572
Stephen Szutenbach: Sure.

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00:19:00.927 --> 00:19:05.667
Jennifer Youssef: Does evidence based design mean to you? And how do you use it? At event? Health.

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00:19:06.188 --> 00:19:18.385
Stephen Szutenbach: Well, having number one. Thank you, Jessica, for that really great setup, because I I was lucky enough to work with you in the brass field and arsenh and Tlc. Team on the Myu project

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00:19:19.152 --> 00:19:27.376
Stephen Szutenbach: at Altimet. And you know I I think you know. Wh what does it mean to me really is? It's an interesting, constant, interesting question to me. One is that

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00:19:27.877 --> 00:19:50.976
Stephen Szutenbach: being an architect, I can say this without any malice. I I had the I had the honor, absolute honor of being on thesis juries master's thesis juries for for graduating architects at at a local university recently, and the work was phenomenal. But what I was at was really struck by was the fact that we, as architects, do really really well, in the qualitative arena.

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00:19:51.037 --> 00:19:56.366
Stephen Szutenbach: we we understand. And we are able to kind of get our heads around.

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00:19:57.077 --> 00:20:23.516
Stephen Szutenbach: you know, how do we kind of take different inputs and and qualitative inputs. But we are not very good at quantitative things. I mean dimensions. And you know, building sizes. Yeah, we we can take care of that. But from a research standpoint, that's kind of not where our education lies. And so I think, what what is interesting about evidence based design having been on both sides of the the table, both as the architect and the client.

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00:20:23.517 --> 00:20:39.096
Stephen Szutenbach: I think that evidence based design is is an untapped resource that I think that both the the industry and also the industry, architectural industry, but also on the client side. That that is is not quite yet fully

83
00:20:39.617 --> 00:20:40.707
Stephen Szutenbach: utilized.

84
00:20:41.141 --> 00:20:45.287
Stephen Szutenbach: Because I think sometimes firms don't necessarily know how to

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00:20:46.027 --> 00:20:56.868
Stephen Szutenbach: do the qualitative or the quantitative, even though we are full user groups are quantitative or qualitative. Excuse our qualitative data gathering right? That that is basically, you know, qualitative data gathering.

86
00:20:57.257 --> 00:21:17.875
Stephen Szutenbach: but I think that we don't always know how to put this into practice, and so I think that it it sometimes it it can. It can be a a risk. It can be risky for us to use that term if we don't have the the muscle behind. How to put it in practice. And so I think it's really important that when we do talk about Evan spaces and we're talking about it truly, with

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00:21:18.816 --> 00:21:37.847
Stephen Szutenbach: rigor and and putting to putting the the 8 steps to find, find, you know, interpret, create hypothesis, putting that and and and into the practice. And so some things that I really appreciated about our miu you work at at ultima I wish you that you you put a picture of the mock up where we had all of the users put up the

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00:21:38.197 --> 00:21:45.959
Stephen Szutenbach: the posted notes. Everyone had a different, a different type of user had different different colors. And we collated that into a really

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00:21:46.617 --> 00:21:50.356
Stephen Szutenbach: kind of powerful document that allowed us to see. Okay? Well.

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00:21:50.577 --> 00:21:58.537
Stephen Szutenbach: 7 people are saying 7, 7, you know, 7 distinct people are saying, XY, and Z, and that comes from 2 or 3 different types of user.

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00:21:58.933 --> 00:22:04.096
Stephen Szutenbach: Whether it's an Evs person or whether that's a nurse, or whether that's a physician, or whether that's

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00:22:04.117 --> 00:22:09.576
Stephen Szutenbach: you know, a manager, you know. And and I think I think that was really really powerful to kind of see how

93
00:22:09.607 --> 00:22:11.943
Stephen Szutenbach: things began to relate to each other.

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00:22:12.527 --> 00:22:21.366
Stephen Szutenbach: so I'm sort of answering the the second part of the question, how we use it out in health. We've obviously used it on this project. We've used it on other projects. We just now finished.

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00:22:21.927 --> 00:22:49.617
Stephen Szutenbach: A post occupancy study for another project of ours. at the Orlando campus. And we, we had our architect, our our architectural partner, and our contracting partner go and survey multiple units and multiple of our towers to see how different types of layouts on each of these floors really, ha! Impacted, what's what's very interesting to me about about the the app impact of these is that I think people adjust to whatever they have.

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00:22:50.227 --> 00:23:03.007
Stephen Szutenbach: and that's the that's the struggle with with qualitative studies. Is that what they have is what they have right now generally is what they're gonna say is right, or what they're used to is what they're gonna say is the best way to go about it so human nature is really hard to

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00:23:03.700 --> 00:23:12.486
Stephen Szutenbach: account for in in qualitative studies, because because we are creatures of habit. So that was a long answer to 2 very short questions. But thank you.

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00:23:12.487 --> 00:23:21.296
Jennifer Youssef: That was great. This question is for you, Michael. How can evidence based design principles be integrated into planning and development of new projects.

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00:23:21.387 --> 00:23:25.946
Jennifer Youssef: And this one I'm really interested in because it's coming from, you know your client perspective. Now.

100
00:23:26.137 --> 00:23:31.964
Michael Compton: Yeah, I I think you know. One of the terms I heard Steven say is risky?

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00:23:32.347 --> 00:23:59.517
Michael Compton: And and and if I can elaborate a little further, I I think, as an architect we are encouraged, and often and and experiment, and we call it a practice. Right? We, we we try new things we we recommend to new things. But on on our side of the table we are risk adverse. We absolutely aren't interested in trying new things. We want to do things that are vetted and proven. And and to that point.

102
00:23:59.897 --> 00:24:03.826
Michael Compton: if there's no evidence to support the claims that you're making.

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00:24:03.847 --> 00:24:25.427
Michael Compton: then we're probably less likely to do it right. And and so I you know, how could we implement it? Prove it right? Prove it first and and and so, and that's ease that's actually fairly easily done with this, with the with the research that's already out there. And and and I'll and I'm and I and I'm I'm terrible remembering names. But there was a study

104
00:24:26.167 --> 00:24:26.867
Michael Compton: done

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00:24:26.877 --> 00:24:40.726
Michael Compton: out of Clemson where they talked about or maybe it was am. It might have been Am. And M. It's one of those 2 where they talked about the importance of of of daylight in in patient rooms. Right? And it's become

106
00:24:41.047 --> 00:24:54.287
Michael Compton: almost anecdotal and not supported by the evidence. Right? It's it, you know, like we that feels like something that makes sense. So we're gonna do that. And and and so much so that it's now an Fgi, and it's code, and it's code required, and all that stuff.

107
00:24:54.347 --> 00:25:08.947
Michael Compton: But it it it, you know, all light isn't equal, right? So just having daylight isn't the same as having daylight and views, and and what are the improvements in patient? Not just satisfaction, but actual physiology, right

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00:25:09.411 --> 00:25:24.527
Michael Compton: and if you go way way back to Alvar Alto and the sanatoriums that he was designing TV units that he was designing around getting access to daylight. He they proved that hours of daylight improved the medical condition right? So it's that kind of thing.

109
00:25:24.907 --> 00:25:27.847
Michael Compton: the evidence that we need to see

110
00:25:28.267 --> 00:25:42.716
Michael Compton: because we are risk adverse. So if we want that in in, in integrated into our projects, in our planning, we need the evidence. It just can't be. Well, this is what we've done elsewhere. Well, that's great. But we're not elsewhere. Right? We want. We want to understand

111
00:25:43.155 --> 00:25:45.608
Michael Compton: how you're justifying what you're doing.

112
00:25:46.017 --> 00:25:49.896
Jessica Whitlock: Relying on your you're relying on your design team.

113
00:25:50.377 --> 00:25:52.717
Michael Compton: All day, every day, all day, every day.

114
00:25:53.057 --> 00:25:54.077
Jessica Whitlock: Data to you.

115
00:25:54.077 --> 00:25:55.867
Michael Compton: That's right. That's right.

116
00:25:55.867 --> 00:26:16.267
Jessica Whitlock: And that's a that's a that's that's a responsibility. I think, of our design community is to be able to. And all the different firms that I don't doesn't really matter who you're with that we take. We don't take that lightly that we need to go out there and get that information, either know how to get that data and be able to implement it or create our own data ourselves and bringing that

117
00:26:16.267 --> 00:26:25.788
Jessica Whitlock: to our client as a part of our the fact that we're, you know, your trusted advisor and helping you make those decisions. That's what you're you're relying on us to do.

118
00:26:26.077 --> 00:26:36.132
Michael Compton: So. So if I can expand my answer to that question, Jennifer, I I think one of the things that you know the center for health design has in place

119
00:26:36.577 --> 00:26:45.407
Michael Compton: something that I think they still call it the Pebble Project, and that's the idea that you are are going to propose or theorize

120
00:26:45.889 --> 00:26:55.047
Michael Compton: a a new solution to an existing problem. And instead of simply bringing the answer to us and saying, Here's the proof you should do this.

121
00:26:55.127 --> 00:27:22.817
Michael Compton: We think this is the proof. Do you have an opportunity to test it in your facility? Right? And that's really what the pebble projects about. And I think that's the kind of thing that we are interested in also. So it isn't only you all bringing this to us. It it is what what problems we have now that maybe you can help us solve and and then in by solving it, add to the the amount of

122
00:27:22.817 --> 00:27:42.007
Michael Compton: data that's out there. That would that would help others. Right? That's our ultimate goal is is to improve the the outcomes of our patients and and our staff truthfully and and how how they experience life and and in in our spaces. And so that's

123
00:27:42.057 --> 00:27:43.698
Michael Compton: yeah. I don't. I'm I'm

124
00:27:44.047 --> 00:27:46.146
Michael Compton: I'm wordsmithing now. But go ahead.

125
00:27:47.007 --> 00:28:03.056
Jennifer Youssef: And so I'm gonna throw this back this next question over to Steven. It's going back to that Myu project. So how did your team

go about like the idea of improving what was there, and what does that conversation look like at a higher level? Once.

126
00:28:03.417 --> 00:28:12.036
Jennifer Youssef: you know, once the idea came to renovate. And you guys did something interesting where you remove beds? You you made that you made that department smaller.

127
00:28:12.037 --> 00:28:13.529
Stephen Szutenbach: Yeah, we did.

128
00:28:14.377 --> 00:28:28.386
Stephen Szutenbach: I I think that there's there are a couple of things we did. Number one, you know. Th, this this unit had been working in in 1,972 tower with you know. Non.

129
00:28:28.837 --> 00:28:49.462
Stephen Szutenbach: they they they they were code compliant in 1972. So I think almost anything that we would have done for them. They would have been like, yes, absolutely. It's better. So. You know. The I'm I'm gonna say the bar was low, but I think what was was gracing. Well, not we. We don't just wanna make it better. We wanna make it right. And we wanna make it work as an optimize for you.

130
00:28:49.817 --> 00:29:06.634
Stephen Szutenbach: And and so part of that was, you know, thinking about data, not just from a, you know, design standpoint, but like we had to figure out what is the right number of rooms for this unit, like what is what you know, we had you the data of of volumes over the past 5 years and figure out it, can. You know

131
00:29:06.907 --> 00:29:28.037
Stephen Szutenbach: we we did not make every room larger, but we did renovate every room. But so like, how do we like? How do we figure out? Number one? What is the what is the optimal size for the community. To serve that this community that we're that we're providing ob care for and then make sure that we're we're not downsizing the unit to the point where we're gonna have. We're gonna have volume and and length of stay and and

132

00:29:28.733 --> 00:29:31.890
Stephen Szutenbach: backups, you know, struggles. So

133
00:29:32.587 --> 00:29:38.447
Stephen Szutenbach: that was, that was the first thing. The second thing the design team that really was able to do is we we didn't start out with

134
00:29:38.897 --> 00:30:01.937
Stephen Szutenbach: a plan we didn't start out with. Okay here. And and I think that's what we often do in the design team, like we think everything is solvable by a drawing or a design, or an aesthetic of some sort. And I think that that can be a a mistake. I I I follow that all the time like, Hey, I have an idea. This is, let me show you, and people get excited by that. But we we started out with first principles, we said, Okay.

135
00:30:01.937 --> 00:30:09.906
Stephen Szutenbach: what is the purpose of these rooms? And actually, one of the hardest things about this whole project is, I think, Jessica correct me, I think we at the end of the project we had

136
00:30:10.037 --> 00:30:11.807
Stephen Szutenbach: 7 distinct

137
00:30:12.066 --> 00:30:13.467
Stephen Szutenbach: types of rooms.

138
00:30:13.626 --> 00:30:14.736
Jessica Whitlock: Yep, that's correct.

139
00:30:14.737 --> 00:30:21.486
Stephen Szutenbach: Yeah. So like, you know, we didn't have like one patient room. We literally had to design 7 patient rooms to be optimized.

140
00:30:21.747 --> 00:30:26.557
Stephen Szutenbach: If we'd had unlimited funds, we probably would have mocked up all 7 types.

141
00:30:27.084 --> 00:30:33.537
Stephen Szutenbach: or space. But we did not have space or funds for that. So we we? You start out by saying, Okay.

142
00:30:33.677 --> 00:30:38.547
Stephen Szutenbach: let's look at our our new, our new room type, which is the double, the 2 rooms becoming one.

143
00:30:38.637 --> 00:30:49.367
Stephen Szutenbach: And how do we make this kind of our our optimal? You know. You know best case scenario. That's when we mocked up. Then we you know, we mocked it up with. We didn't do materials, but we mocked it up with

144
00:30:49.784 --> 00:31:06.679
Stephen Szutenbach: everything other than kind of the final finish materials. And we had. We had, you know. Physicians, doctors? Well, physicians about the same thing. Physicians nurses administrators, everyone come and spend time in it. We had multiple long work sessions in there.

145
00:31:07.735 --> 00:31:15.836
Stephen Szutenbach: and that was after we kind of did kind of a a a a front of beginning survey and say, W, what does it look like, you know? What does your ideal look like?

146
00:31:15.927 --> 00:31:43.087
Stephen Szutenbach: And then from there we began to refine it more, and then what we tried to do with the other 6 other patient room types as well. How do we refine this data that we have here? Into these? You know other you know, Russian doll diminishing size rooms. how do we? How do we kind of make these strategies work on those other rooms to maximize patient flow. Help our our clinicians work best.

147
00:31:43.408 --> 00:31:56.426
Stephen Szutenbach: And what's interesting is, yes, so we are now. And we're about to finish phase 3 of 4 of that. This project phase, one is now open and it is the what's interesting is there? There are things that we're learning about that we didn't think about.

148
00:31:56.747 --> 00:32:06.056
Stephen Szutenbach: That no one thought about but they're, you know, by and large the decisions that we made are being validated by by the users, but also by the clinicians.

149
00:32:06.334 --> 00:32:22.667
Stephen Szutenbach: And and you know they they are absolutely even even though the the new rooms are the same. Some of the new rooms are the exact same sizes, the unrevated rooms right now. They are always trying to put patients in the new rooms because they flow better. They work better. And and they're better for both patients and staff.

150
00:32:23.757 --> 00:32:26.176
Jessica Whitlock: And I'd like to also kind of add on to that

151
00:32:26.579 --> 00:32:36.136
Jessica Whitlock: going back to the conversation around that mockup another thing that we made sure that we had in that room is every piece of

152
00:32:36.157 --> 00:32:59.656
Jessica Whitlock: as much as we could piece of equipment furniture that we could potentially put in there because we went down to the details, even where the sharps container was going to be hung on the wall. And I do think that a lot of people, you know. Some of those things can be an oversight, and then when you go to install them on site, it's just a an uncoordinated, you know mess. And so that is a huge

153
00:32:59.987 --> 00:33:10.767
Jessica Whitlock: step in the operational flow for a clinician team of where that is stored. What zone that's in in the clinical zone. Also. Then, being able to kind of see

154
00:33:10.907 --> 00:33:36.747
Jessica Whitlock: how that furniture is going to be in the space to scale what it's gonna feel like, how much space they have. And it's just a more of a better visual. So I would really encourage anyone that's doing any type of full scale mockup of a room to make sure you have, as much as you can all your components available to be able to go inside that mockup, to

have the best view you can. The more realistic view you can, as you're starting to, you know.

155
00:33:36.957 --> 00:33:39.707
Jessica Whitlock: bring a lot of that data to the surface.

156
00:33:39.707 --> 00:33:42.027
Stephen Szutenbach: 1 one other tag onto that is that

157
00:33:42.367 --> 00:34:04.146
Stephen Szutenbach: if your budget allows it, I I I recommend doing a full mock up with finishes, too, because I think that actually makes a difference finishes doors, everything else. There are things that you find as much as we all of us do this every day. There's every project has little pitfalls. You're like, Wow! That that wasn't. That was like, for example, we had a situation on on this where

158
00:34:04.157 --> 00:34:05.896
Stephen Szutenbach: the door swing.

159
00:34:07.057 --> 00:34:31.096
Stephen Szutenbach: basis. So had it's complicated. But the door swing and the the bass and net had an issue together. And and so we you know that because we didn't actually have a full door that swung. You know. There, there are things you just kind of, you know. Don't think about necessarily when you're doing that. And so like, we had to kind of adjust that in the field and figure out a solution after the fact, which is okay, we're we're all problem solvers. But you know,

160
00:34:31.367 --> 00:34:42.506
Stephen Szutenbach: I think as as close to the the final product as you can possibly afford, I think, is always best, especially if you're doing. Really, you know, a tower with, you know, 30 of the same kind of room.

161
00:34:43.047 --> 00:34:46.926
Stephen Szutenbach: Do a full mockup cause that's that's gonna give you the most evidence.

162

00:34:46.927 --> 00:34:47.637
Jessica Whitlock: Shooting them.

163
00:34:49.497 --> 00:34:57.647
Jennifer Youssef: Excellent. So my next question is, gonna be for Michael? So what's your opinion on a post? Evaluate a post accuracy, evaluation?

164
00:34:57.913 --> 00:35:01.496
Jennifer Youssef: And what does that look like for you? And do you actually use them.

165
00:35:02.247 --> 00:35:12.707
Michael Compton: So so we do use them. Matter of fact, Steven just talked about one we conducted recently, and and he can talk more intelligently about the results of that.

166
00:35:14.421 --> 00:35:35.826
Michael Compton: What's my opinion of them? Well, they're only as useful as the responses. You get right. And and so, if you're if you sent out a hundred surveys and you got 30 back. That's not really useful, right? Because you're not getting a large enough sample size. So you need you need to make sure you get a large enough sample size to have any real value.

167
00:35:36.386 --> 00:35:50.056
Michael Compton: But I also think they are. It isn't an isolated, a a event meaning you. You do one, maybe 6 months post occupancy, maybe one year, post occupancy, maybe 5 year post occupancy, or whatever, because

168
00:35:50.277 --> 00:36:04.336
Michael Compton: the thing that is constant is change. Change is always present, and it's not just in the room, or the way we conduct, or or we provide medicine, or we provide care. It's also in our staff.

169
00:36:04.507 --> 00:36:28.357
Michael Compton: right? Like like we have staff turnover, and I don't mean like the they. They hate it here, or they love it. Here we have. We have staff who who advance quickly, and they move on to to different positions. And so we're bringing new folks in. Well, the folks we're

bringing in we're trained differently. So all the decisions we made around that department around the people who were running that department at that time

170
00:36:28.477 --> 00:36:29.587
Michael Compton: have shifted.

171
00:36:29.977 --> 00:36:55.882
Michael Compton: And so if if the decisions were made rooted in evidence in the and best practices, right? And here we go again right? Then they're probably gonna be a seamless transition in the way. Provide care. And and that's new folks coming in are just gonna be able to pick up and run. I'm talking a little bit about standardization. But I'm also talking about the results of Prior Poe's and how they influence the changes in our room design in our operational flow.

172
00:36:56.187 --> 00:37:03.116
Michael Compton: So we absolutely use them. We, we, we find great value in them, provided they are

173
00:37:04.317 --> 00:37:05.467
Michael Compton: well

174
00:37:05.497 --> 00:37:11.406
Michael Compton: provide. We get them back in in in large enough return to make to make any value.

175
00:37:11.727 --> 00:37:14.157
Michael Compton: I don't know if I got where you wanted to go with that, but.

176
00:37:14.357 --> 00:37:15.367
Jennifer Youssef: No, I think so.

177
00:37:15.581 --> 00:37:17.296
Stephen Szutenbach: Can I? Can I add to that too.

178
00:37:17.297 --> 00:37:17.687
Michael Compton: Yeah.

179
00:37:17.687 --> 00:37:18.207
Stephen Szutenbach: You didn't.

180
00:37:18.207 --> 00:37:18.677
Jennifer Youssef: Who, so?

181
00:37:18.677 --> 00:37:20.979
Stephen Szutenbach: So so there's 2 things. One is that

182
00:37:21.307 --> 00:37:23.397
Stephen Szutenbach: pui's are extraordinarily useful.

183
00:37:23.755 --> 00:37:31.308
Stephen Szutenbach: I I'm gonna put a call out. So all our architectural partners out there that I think that there's a missing opportunity.

184
00:37:32.684 --> 00:37:50.146
Stephen Szutenbach: for so a service line to offer of of just a really kind of dedicated. You know we we do Poe's, we do. We do e evidence based design, I think. I think, having a really rigorous team that does that, I think, is an as an is an opportunity. Because, as I said, I think we, as architects generally aren't.

185
00:37:50.237 --> 00:37:52.706
Stephen Szutenbach: aren't trained or hardwired to do this kind of work.

186
00:37:53.077 --> 00:38:06.137
Stephen Szutenbach: The big struggle that we have is again. You know, our, our, our clinical staff are, are are busy. Are they really really busy. And so as much as you try to put a survey in front of them, they're like, I have 30Â s.

187

00:38:06.547 --> 00:38:32.846
Stephen Szutenbach: And so what is, you know, so so designing it in a way that you can engage your clinical staff and get an appropriate amount of data is appropriate to make conclusions off of is really important. Number one, number 2. That the other thing I was gonna say is that I find it so interesting, maybe a little bit meta that so so much of what we do, we think is, you know, based on evidence based evidence. And so so the the Poe that we just completed.

188
00:38:33.037 --> 00:38:35.266
Stephen Szutenbach: One of the questions we taught we asked was.

189
00:38:35.337 --> 00:38:49.226
Stephen Szutenbach: you know, we had one unit where we had we had built distributed patient nursing stations. So we had like 3 nursing stations on a unit. Because we wanted to have nurses more distributed around closer to their patients.

190
00:38:49.599 --> 00:38:56.627
Stephen Szutenbach: And that's what. At the time I the you know, the the clinicians, were telling us. That's what they wanted better for the patients.

191
00:38:58.097 --> 00:39:19.281
Stephen Szutenbach: They hate it and they all gather at one nurse station because they want, because we are pack people pack animals right? We wanna be around our people. And so like. What that ended up happening is that you end up with like this one nurse station that's completely over overloaded. And then 2 empty workstations. Right? So so you know,

192
00:39:19.647 --> 00:39:39.913
Stephen Szutenbach: And and it's not like we made that decision in a vacuum, right? We you know, we didn't make the decision to make 3 nurse stations be like, because, you know, Mr. Mrs. Architect were like, I want 3, you know. It was like, Oh, this is me better for visibility, and we're trying to meet the the the guideline, you know, kind of intention of kind of creating, distributing caregivers around the unit.

193
00:39:40.467 --> 00:39:41.437
Stephen Szutenbach: and yet

194
00:39:41.947 --> 00:40:01.496
Stephen Szutenbach: so as much as we want to think that we have power over people with our design. We don't. I mean, how many times have those of us in this room gone to a space that we've designed be like. That's not how that's not being used. How it's designed, don't you know, you don't have to put command strips on the door, because there's magnets next to it, for all your you know, I mean, like, you know.

195
00:40:01.707 --> 00:40:02.547
Jessica Whitlock: You guys and all.

196
00:40:02.547 --> 00:40:10.297
Stephen Szutenbach: No matter what it is we we've all seen this right? So you know, I think what we have to do is figure out what is the

197
00:40:11.517 --> 00:40:14.987
Stephen Szutenbach: The best way to design it in a way that is the most flexible.

198
00:40:15.577 --> 00:40:43.466
Michael Compton: And and and intuitive right? So so you know, you just hit a a point on that. I at least I think I was trying to make is, you know, our our folks are constantly moving on and and into better roles and different places, and whatever. And so we go through what we call a go live process. So at the end of every capital improvement, we take a requisite amount of time, depending on the complexity of the project to onboard the team, right to say, Okay, here's your new space. This is how you use it, whatever

199
00:40:43.467 --> 00:40:54.277
Michael Compton: that's good for about 3 months, and then 3 to 6 months. You have an entirely new team who didn't go through that process, and they're like, I don't know where to find things. I don't know where things are, and so.

200
00:40:54.307 --> 00:41:06.829
Michael Compton: you know we it has to be intuitive. It has to be flexible. That's another keyword that that should be coming up more more often. But yeah, I I I totally agree.

201
00:41:07.407 --> 00:41:10.947
Michael Compton: And and I also think that again.

202
00:41:11.297 --> 00:41:19.666
Michael Compton: we're we're happy to be a test bed, but we also want it to be a proven strategy. We don't. We don't want to. We are risk adverse.

203
00:41:20.527 --> 00:41:36.741
Jennifer Youssef: This is a great segue, so at Ashley, Pdc. I attended a a round table, and 3 owners were speaking, and one thing they did, which I thought was really interesting. Was they put a call out to architects to bring them data, right, support,

204
00:41:37.487 --> 00:41:44.177
Jennifer Youssef: their ideas, and to support these changes? How often are are people bringing you data.

205
00:41:46.927 --> 00:41:52.076
Michael Compton: probably. And and maybe Steve and I might have a different answer. Not as often as we'd like

206
00:41:52.577 --> 00:42:09.657
Michael Compton: right? I I I think we? We would like more. And and you know, often we are pressed between between time to to to install and delivery and and and make operational right? But at the same time we need enough time

207
00:42:10.143 --> 00:42:15.357
Michael Compton: to to to test the things that we just did. So we don't go live and and

208
00:42:15.567 --> 00:42:20.534
Michael Compton: has something happened? And we didn't. We didn't foresee it right? So so

209
00:42:20.947 --> 00:42:42.477

Michael Compton: we get, we get some and and we and we get a good amount. But we need more. We want more data. And and and because these things aren't always free, right? Sometimes these things are cost. The first cost is fairly large, and we have to justify our to our superiors and and our leadership.

210
00:42:42.477 --> 00:42:59.046
Michael Compton: Hey, we know this is X right, but if you pay X. The Roi is less than 2 years, and we're gonna see patient improvements. We're gonna see staff and improvements, efficiency improvements like ex, you know whatever. But again.

211
00:42:59.167 --> 00:43:03.667
Michael Compton: we don't have the time to pull that data together. We need that data to present it to us.

212
00:43:04.115 --> 00:43:06.856
Michael Compton: And then we can do the bring the financial piece of it.

213
00:43:07.907 --> 00:43:37.747
Jessica Whitlock: I think, also in in kind of spinning off of that is, these conversations need to happen earlier, right? Because they have to not only be budgeted for, but they have to be scheduled for, and they have to be talked about, so that when we're creating the design schedule, we're fitting that opportunity for mock ups or testing, or whatever that looks like within the project. If it's, you know, project specific, I think it'd be all great and dandy. We're able to do these side projects of trying to find data.

214
00:43:37.927 --> 00:43:46.006
Jessica Whitlock: you know. But we know that that's not reality reality, that we're trying to find data provide data, approved data is within a project.

215
00:43:46.117 --> 00:44:14.516
Jessica Whitlock: because that's what is driving us to get that information. And so we can have these conversations earlier. So that you guys are in a situation. Well, position to be able to go and ask for that money, or to be able to make sure we allocate the right funds around it. And also it puts us in a good position to be able to make sure we're providing that within the overall design schedule. So we're not, you

know, trying to catch it, you know, during design. And and then it just keeps, you know.

216
00:44:14.597 --> 00:44:18.667
Jessica Whitlock: taking us off track. So I I I can't express

217
00:44:19.147 --> 00:44:23.476
Jessica Whitlock: enough that some of these conversations have happened early on, for example.

218
00:44:23.477 --> 00:44:24.067
Michael Compton: Yeah.

219
00:44:24.067 --> 00:44:25.577
Jessica Whitlock: The way that we need it to.

220
00:44:25.577 --> 00:44:31.744
Stephen Szutenbach: I I I think I think it's an interesting symbiosis that needs to begin to happening more.

221
00:44:32.147 --> 00:44:41.196
Stephen Szutenbach: meaning that that I think we need the design community to to be the gatherers of the data to help us gather the data. But you need, you need, you know.

222
00:44:41.287 --> 00:44:43.737
Stephen Szutenbach: hospitals to help you have access

223
00:44:43.877 --> 00:44:47.167
Stephen Szutenbach: to to do that. I think that we all

224
00:44:47.187 --> 00:44:56.116
Stephen Szutenbach: have a really, we all have great intentions of doing Poe's, you know, a year after our projects are done. But I I think that we we don't often do that.

225
00:44:57.697 --> 00:45:24.506
Stephen Szutenbach: you know we get busy. We forget about it. There's money. It. It costs something to do that. And so what tends to happen, I think, is that we don't do Poe's until, like all of a sudden, we have a need to like 10 years later, like, Oh, well, is this working? Right, you know, and so we don't really have a maybe a a strict or a rigorous process in place to really kind of capture that data both on on the hospital side, but also on the on the architect side. I mean, I think that

226
00:45:25.014 --> 00:45:32.527
Stephen Szutenbach: I think architects and and designers can begin to build their data by building Poe's into their fees.

227
00:45:32.976 --> 00:45:42.146
Stephen Szutenbach: Originally, we're gonna do Poe's because we needed we needed ourselves. This is actually virtuous for us, because it's gonna help us, you know, and it'll help you see if something's working or not.

228
00:45:42.422 --> 00:45:50.657
Stephen Szutenbach: You know. And so I think that that is something that that data, I think, is is really the the gold that we're looking for, but I think it is also.

229
00:45:50.667 --> 00:45:54.127
Stephen Szutenbach: It's a rare commodity in in. In. In this.

230
00:45:54.137 --> 00:45:57.617
Stephen Szutenbach: you know, in the healthcare, you know, design space.

231
00:45:57.617 --> 00:46:02.622
Michael Compton: It. It it is. And and I saw a comment come through saying, data is expensive.

232
00:46:02.977 --> 00:46:05.347
Michael Compton: What recommendations do we have?

233
00:46:05.427 --> 00:46:25.087
Michael Compton: And I will tell you from my own experience. Public private partnerships are are a way to go. I know that there the Federal Government has offered several grants on on collecting data in the architecture space. And I know that there are quite a few universities. I mentioned a few of them

234
00:46:25.628 --> 00:46:28.035
Michael Compton: Clemson, Texas A. And M.

235
00:46:29.008 --> 00:46:34.476
Michael Compton: I think K. State, and then and then the the school in Ohio. There.

236
00:46:34.517 --> 00:46:51.656
Michael Compton: Kent, I'm sorry. Kent State. That's what I meant. so so there's there's quite a few schools that are very interested in in in partnering, but you know for them it has to get beyond hypothetical. They need a Pre. They need a real live place to do this. We're the live place to do it, but we can't. We can't

237
00:46:51.687 --> 00:47:10.365
Michael Compton: spend the money to to collect the data. They can collect the data, probably to discount rate. And the architect is the one who's sort of collating all of this right? So I I I think it. It is not incumbent on any one entity. I think Steven hit nail on the head. I think it's a symbiotic relationship between multiple entities.

238
00:47:11.098 --> 00:47:15.015
Michael Compton: And and I think you know, some owners would be

239
00:47:15.617 --> 00:47:24.426
Michael Compton: would be willing to pay a small premium if it means that they're gonna get better products or out of the development of their projects.

240
00:47:24.909 --> 00:47:40.476
Michael Compton: I I'll say one other thing. You know, I I worked. I've worked for quite a few firms. One firm was a member of the Advisory

Board, and there's a large report repository of of data there that you simply can consume.

241
00:47:40.898 --> 00:48:06.773
Michael Compton: I left that firm went to a different firm, and they weren't members. And so that was like, you know, having the air pulled out of the room. For me. It was, it was. It was tough. And so I had, though, relationships at at different schools. David Alison got tired of me, so you know, just reach out to the people that you know, and and they're more than happy to to help you do. If nothing else

242
00:48:08.191 --> 00:48:17.409
Michael Compton: a peer review search and and to try to find I mean a journal search to try to to find some data that's applicable to your project.

243
00:48:17.967 --> 00:48:19.346
Michael Compton: so there's a couple ideas.

244
00:48:19.577 --> 00:48:30.576
Jennifer Youssef: And I'd like to double down on your statement, Michael, you know and this came from Vicki. So Vicki, you know, feel free to reach out to us and cause. I believe that the community should be helping each other.

245
00:48:30.577 --> 00:48:31.617
Jessica Whitlock: Yes, and.

246
00:48:31.617 --> 00:48:35.706
Jennifer Youssef: So. You know, if there's something you're looking for, you know.

247
00:48:35.727 --> 00:48:47.077
Jennifer Youssef: By all means ask, you know. Ask us, you know, if we have access to that data or whatever you're looking for. We're happy to share. Because this is, you know, this is about making.

248
00:48:47.107 --> 00:48:56.096

Jennifer Youssef: We're all passionate about this, I think, on the on the call, and probably our pen. You know, the people who are viewing and yeah. And we would love. We would love to be part of that knowledge sharing

249
00:48:59.196 --> 00:49:13.447
Jennifer Youssef: we've got probably time for one more question, and then we have another. Well, actually, I'm gonna go to the chat because, so did you guys get any patient consumer input on the markup? Or can you describe what your input was on the mockup for the miu.

250
00:49:13.707 --> 00:49:18.882
Stephen Szutenbach: Yeah, that's a really good question. We had a lot of conversation about this actually,

251
00:49:19.247 --> 00:49:22.957
Stephen Szutenbach: and and you know, we

252
00:49:23.407 --> 00:49:29.535
Stephen Szutenbach: we didn't end up bringing in a patient, and we did not end up bringing in like a future patient. So

253
00:49:30.587 --> 00:49:45.096
Stephen Szutenbach: The. There was a lot of there are lots of kind of considerations about this, and and at the time I I I think it would have been a a really interesting thing to have done. But I think what's what's complicated about that is that is it for very particular units and obits. So there's, you know.

254
00:49:45.157 --> 00:49:57.116
Stephen Szutenbach: you could bring in someone who's pregnant, and it's gonna be. But most of the time it's a I think the conversation at the time was that it was a more technical conversation with the clinicians, and they didn't want to kind of

255
00:49:57.817 --> 00:50:05.386
Stephen Szutenbach: muddy that water. So. And and that's that's kind of where you know we that that was the the Leadership Directive. And and whether that's

256
00:50:05.597 --> 00:50:09.261
Stephen Szutenbach: I, I think that I think there are pros and cons to both sides of doing that.

257
00:50:10.067 --> 00:50:17.897
Stephen Szutenbach: so I think one of the big concerns was like, you know, this this area wasn't going to be, you know, renovated in time for most of these patients to see this

258
00:50:18.197 --> 00:50:27.336
Stephen Szutenbach: and so they were gonna be like, well, we we want. We don't want them to feel like they're not getting, you know, the the the new in time for that. So, but it's a really good question.

259
00:50:28.757 --> 00:50:31.116
Jessica Whitlock: It would be very interesting, though, to

260
00:50:31.297 --> 00:50:47.366
Jessica Whitlock: be in a position to be able to bring in a patient consumer into a study like that, especially a a mock up driven and if anyone had, has has had an opportunity to do that, I would love to hear more about it, and how you got that

261
00:50:47.387 --> 00:51:08.127
Jessica Whitlock: process started and how you went about including them. Because I feel like it's completely different Avenue. And it's a whole, completely different process of involving more of the patient consumer than it is involving the clinical team design team and executive team. I think there's a a different approach that you would have to go through to be able to make that happen. So I think that's very interesting. So thank you for that question.

262
00:51:08.127 --> 00:51:15.397
Stephen Szutenbach: It's a really interesting, actually. So this morning I was just meeting with the director of that unit and she mentioned to me that they are

263
00:51:15.717 --> 00:51:31.887

Stephen Szutenbach: when they're they're pretty full right now. So they've got patients in new rooms and old rooms, and they are moving. As soon as a new room will open up they will. Oh, they will move the the patients from the old room to the new room. And so I'm really curious, I think, be really curious. Interesting to hear

264
00:51:32.277 --> 00:51:37.046
Stephen Szutenbach: what the reaction is between the 2. Actually, I think that'd be an interesting kind of

265
00:51:38.657 --> 00:51:39.677
Stephen Szutenbach: data point.

266
00:51:40.027 --> 00:51:45.807
Jessica Whitlock: Yeah, that sounds like a very in the future field trip for us. I feel like.

267
00:51:46.487 --> 00:51:54.897
Michael Compton: I can share with you that we've had both pre and post we call them patient advocates. As part of our projects

268
00:51:55.537 --> 00:52:01.976
Michael Compton: Pre, they weren't necessarily making design decisions. They were simply reacting to design decisions that have already been made.

269
00:52:02.057 --> 00:52:17.796
Michael Compton: And then post were what it sounds like, you know. So I thought I read somewhere earlier that, you know, do we survey the patients? In addition to the staff and and absolutely the patients get surveyed in addition to staff

270
00:52:18.142 --> 00:52:24.871
Michael Compton: and facilities. Because if our our facilities folks need to be able to maintain these things that we come up with

271
00:52:25.688 --> 00:52:35.025

Michael Compton: and if they can't maintain or the educate again, it isn't intuitive, then they don't get maintained, and patients are dissatisfied. So patient satisfaction is a big deal.

272
00:52:35.347 --> 00:52:51.107
Jessica Whitlock: And I'm so glad you mentioned that, Mike, because I do. I do feel like when people are when teams are selecting and designing for different projects. The facility team always gets left out for the most case, and I feel like that is some such a vital

273
00:52:51.447 --> 00:53:13.837
Jessica Whitlock: team to be able to have come in and group be able to give the recommendations and to be able to to tell the team. Yes, that's something that's we're used to maintaining, or that, or here's why this won't work, or here's why it's kind of a a challenge for, especially with furniture. I I really think that they don't really get a good glimpse of it. And then, next thing you know, they're the ones maintaining it.

274
00:53:13.977 --> 00:53:14.787
Jessica Whitlock: and.

275
00:53:14.787 --> 00:53:16.466
Michael Compton: Or throwing it away when they realize.

276
00:53:16.467 --> 00:53:17.977
Jessica Whitlock: Yeah. Can't maintain it. Yeah.

277
00:53:17.977 --> 00:53:22.397
Michael Compton: And it could be simply refurbished, but they just throw it away right.

278
00:53:22.737 --> 00:53:25.776
Jessica Whitlock: So always, always remember your facilities, team.

279
00:53:25.777 --> 00:53:40.076
Michael Compton: Yeah, that that that's a for all the architects who are listening, you're like, how do I talk to my owner about this? Just tell them, hey, are we going to talk to facilities? Are we going to talk to

Evs, or whatever they call them in there? Yes, that's okay. You're allowed to. You're allowed to ask those questions, please.

280
00:53:41.007 --> 00:53:43.176
Michael Compton: and we're pretty smart, but we're not that smart.

281
00:53:45.115 --> 00:53:59.127
Jennifer Youssef: What am I? We have probably time for one more question. And so and this is for both you and Mike and Steven. Sorry I'm looking at both. Y'all. This technology play and advancing. Ebd, or what have you seen.

282
00:53:59.937 --> 00:54:01.831
Michael Compton: Oh! What have we seen? Well.

283
00:54:02.147 --> 00:54:03.147
Jennifer Youssef: I know it's tricky.

284
00:54:03.467 --> 00:54:20.876
Michael Compton: Yeah, you know, I I guess I have 2 responses. You know, back in the in the in grad school days, when I was the guy counting people sitting up and standing down from a waiting room to see how many actually waiting room chairs they needed. I mean, that's the kind of the the I go way back like I've been collecting data for.

285
00:54:20.877 --> 00:54:21.356
Jessica Whitlock: Play, but.

286
00:54:21.701 --> 00:54:22.047
Michael Compton: Yeah.

287
00:54:22.047 --> 00:54:22.537
Jessica Whitlock: Who.

288
00:54:22.537 --> 00:54:23.077
Michael Compton: Yeah.

289
00:54:23.407 --> 00:54:50.416
Michael Compton: So so I I think I think you know, in that particular example, when when you have field observations as part of your study right? And and you can use technology to count seats and or buts and seats versus someone stationed there watching people get up and get down. That's that's a really critical piece of technology that added value to the data collection sphere.

290
00:54:50.733 --> 00:55:17.407
Michael Compton: That's certainly part of it. Digitize surveys. I know it sounds dumb, but that's a huge bonus right over paper surveys that. Oh, it's I gotta fill it out. I don't have a pen. Who do I give it to. When I'm done. Ebs comes in. They see a survey laying on the table like app. Throw it away right now. Our, not our evs. They, they would never do that. But you see, I mean, so I think technology has come. A A actually has added a lot of value.

291
00:55:17.986 --> 00:55:24.996
Michael Compton: But it is also for for some of our population pitch population. It also is a roadblock.

292
00:55:25.157 --> 00:55:30.066
Michael Compton: right? They don't know how to use the the technology, and therefore they don't do it.

293
00:55:30.097 --> 00:55:33.836
Michael Compton: So it's. It's a double edged sword, I guess.

294
00:55:35.137 --> 00:55:43.437
Stephen Szutenbach: I think to, I think. That's Mike. That's very well said, and I don't have a whole lot to add to that. But in the Poe that we just finished in Orlando.

295
00:55:45.293 --> 00:55:48.127
Stephen Szutenbach: they use utilize survey monkey

296
00:55:48.406 --> 00:55:56.707

Stephen Szutenbach: and and Han Brady was our team that that worked on that they did a great job on that, and a very tight window, so that kudos to them as well.

297
00:55:57.257 --> 00:56:20.526
Stephen Szutenbach: they in in in survey, monkey like. What was great about that to your point was that they immediately had a platform in which they could slice and dice the data differently and look at. You know how different responses led to like by unit, whether it's by unit or by by shift or by, you know, you know. And it was a really interesting kind of easier way than kind of having these paper studies that I think it's really helpful.

298
00:56:20.827 --> 00:56:31.927
Stephen Szutenbach: There's there's all kinds of things technologically, that can help us monitoring systems in rooms. But you know, I'm always reminded, though, that sometimes analog is is best. You know, we're I was having a conversation with

299
00:56:32.473 --> 00:56:57.307
Stephen Szutenbach: a woman in charge of parking today. And and we have, you know, you guys have all seen this parking systems that have the red and green lights, and that that are really great. And I tell you, you know how much, how, how those work, and you know she's telling me how often they have to repair those things. And and and so like, I, I think that sometimes technology is a great idea until it breaks, and then, now, you have a dead piece of technology. So sometimes the best technology is

300
00:56:57.307 --> 00:57:07.437
Stephen Szutenbach: is the the technology of our feet, and going a feet and eyes, and going to look and watch and observe, and that in some ways is not a there's no replacement for that.

301
00:57:09.897 --> 00:57:11.397
Jessica Whitlock: It also allows for

302
00:57:11.657 --> 00:57:27.976
Jessica Whitlock: more conversations and deeper conversations. When you're able to do that to you, not you're not really sure what else could come out of that one answer to that one question, unless you're there with that person. And that we've actually, you see, more information come out to. So there I would agree with you. There is just

303
00:57:28.267 --> 00:57:30.527
Jessica Whitlock: this is definitely major pros and cons.

304
00:57:32.357 --> 00:57:52.507
Jennifer Youssef: Excellent. Well, we're at the top of the hour. I'm gonna throw my email into the chat. So for anyone who's listening feel free to reach out to us. And ask any questions. I really wanna thank our our guest panelists. Thank you, Mike and Steven, for joining us today. We really appreciate y'all joining us.

305
00:57:52.827 --> 00:57:54.856
Michael Compton: Thanks for having us. Yeah, I appreciate it.

306
00:57:55.067 --> 00:57:56.047
Michael Compton: Thank you.

307
00:57:56.047 --> 00:57:56.627
Stephen Szutenbach: Is everyone.

308
00:57:56.627 --> 00:57:58.487
Jessica Whitlock: Everyone, bye.