

10.0 Supporting Documentation

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10.1 Review Comments and Responses

The following review comments and responses were generated from the previous submittals:

- Preliminary Submittal
1 November 2013
- Progress Submittal
31 January 2014
- Pre-Final Submittal
7 March 2014

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**VA CBOC Prototype
Preliminary Submittal Review Comments**

ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
1	General	Why isn't the ratio of net to gross more closely aligned among the 3 sizes?	Page 1.1 is showing the Medium Prototype's DGSF (35,370) rather than the BGSF (44,213). The overall NTG factor for each of the prototypes is limited to 1.9 as per the VA guideline. The PFD's in Section 4 are correct. The DGSF and BGSF factors for all three prototypes are 1.52 and 1.25 respectively.	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
2	General	Also, thought best practice calls for the elimination of wait/reception area, with scheduling done electronically in exam rooms.	Those spaces appear in the Draft PACT Space Planning Criteria that was provided by the VA. What is the preferred solution?	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
3	General	Needs editing throughout.	Concur. Will revise for Progress Submittal.	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
4	General	Since VBA is restricted by Net Zero, there has been support for co-locating VBA services at CBOCs. Perhaps this should be considered for the larger prototype.	Who will make the decision to add VBA space? What are the VBA requirements?	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
5	General	Is there any guideline for travel time to or distance between each Small CBOC/Medium CBOC/Large CBOC?	Travel time or distances were not discussed as part of this project.	Ved Gupta	Office of Construction & Facilities Management (CFM)
6	General	A prototype graphic example showing locations and inter-relationship of Small CBOC to Medium/Large may be helpful.	Not included as part of this project. The definition of primary care and specialty care populations served by the S, M, and L CBOC are notional not factual. This does not take the place of individual planning for specific projects.	Ved Gupta	Office of Construction & Facilities Management (CFM)
7	General	Some typo corrections required.	Concur. Will revise for Progress Submittal.	Ved Gupta	Office of Construction & Facilities Management (CFM)
8	General	No comments included for 3 planned CBOCs (I am not familiar with program requirements).	Noted.	Ved Gupta	Office of Construction & Facilities Management (CFM)
9	Section 2	Project Narrative (2nd paragraph) includes functional and efficient; add flexible.	Will include in the Progress Submittal.	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
10	Section 2	PACT Model Overview: Are the four rooms listed all one size and interchangeable? (Small CBOC shows 160 SF procedure, 125 SF exam, 120 SF consult) Best practice calls for universal rooms, at least for exam and consult rooms.	Those room sizes have been taken from the Draft PACT Space Planning Criteria that was provided by the VA. Procedure Room is 180 sf not 160 sf as the comment states. What is the preferred size for the Exam and Consult Room to make them universal?	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
11	Section 2	Am I missing something? Figures 2.3 (One PACT), 2.4 (Two PACT), and 2.5 (Three PACT) are all the same. Why not show one illustration of Defining Characteristics?	This is an error that will be corrected in the Progress Submittal.	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
12	Section 2	Figure 2.3, 2.4 and 2.5--Net SF Space Allocation by Functional Area is same SF in all three versions--One PACT Module, Two PACT Module and Three PACT Module.	This is an error that will be corrected in the Progress Submittal.	Ved Gupta	Office of Construction & Facilities Management (CFM)
13	Section 2 Page 8	are the two and three pact module space diagrams correct. Seems like they should show different spaces...	This is an error that will be corrected in the Progress Submittal.	Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
14	Section 3	large CBOC - typo 14,400 users not 14,200.	This is an error that will be corrected in the Progress Submittal.	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)

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15	Section 3	Scope of Services does not list space for telemedicine. Is that not included for each sized clinic?	Telemedicine does exist in the programs for each clinic under the service that it supports. We can add Telemedicine into the Scope of Services, but we saw it as a method of providing the service it supports...not a product or service line in and of itself.	Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
16	Section 3	2 small CBOCs are planned to be attached to a Medium CBOC and only 3 small CBOCs are attached to a Large CBOC. Large CBOC seems to be very minimally differentiated from Medium CBOC in regards to Clinical and Admin services!! (just my observation). It seems that medium CBOC may be less desirable considering the difference in services.	These prototypes are to show flow and space relationships between the services included but are not meant to replace the individual planning done for each specific project.	Ved Gupta	Office of Construction & Facilities Management (CFM)
17	Section 3	In item 3.2: a. Area for Prosthetics & Sensory Aids is missing b. Areas for Engineering and Police/Security for Large CBOC should be bigger than the area in Medium CBOC	a. It is missing and should be listed as 1,216 DGSF in the Medium column b. The CBOC Space Planning Criteria only calls for a Biomed Shop in the Engineering functional area. Similarly, Security only calls for a 120 sf Ops Room and a 60 sf Holding Room. We did add an Safe (Arms Room) to the M and L. What other spaces should be added?	Ved Gupta	Office of Construction & Facilities Management (CFM)
18	Section 3 Page 11	consider small Dental clinic for Med CBOC	It can be added at the direction of the group.	Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
19	Section 3 Page 12	Does Engineering include facility maint or just Biomed?	Presently, only Biomed is included in the Medium and Large prototypes. The current Space Planning Criteria chapter only includes a Biomed Shop under the Engineering functional area. Does the group want to add additional space for Facilities Maintenance?	Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
20	Section 3 Page 12	consider Blind Vendor or Retail store for Large CBOC	It can be added at the direction of the group. How much space should be allocated to these functions?	Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
21	Section 3 Page 9	Should there be a clinic Administrative service function/space need to each CBOC	It can be added at the direction of the group. What are the requirements for each size prototype?	Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
22	Section 4	Conference room at each facility can also be programmed as a Group Education Room and as such could be a larger room (300-400 SF).	A Shared Medical Appt Room (i.e. Group Room) is included at 400 sf per each PACT Module	Ved Gupta	Office of Construction & Facilities Management (CFM)
23	Section 4 Page 26	Small CBOC should be under 10,000 NUSF for delegated leases	What spaces should be removed from the Small CBOC Prototype?	Tim Bertuccio	VISN 21 Deputy Capital Asset Manager

VA CBOC Prototype Progress Submittal

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1	General	VBA: Met with the Vocation Rehabilitation and Education (VR&E) Central Office staff. They are the group who would be placing the bulk of our out-based personnel in satellite offices. They do have metrics based on Vet Pop data. After our discussions they realized that they need to refine their requirements for an outbased office to inform all of us what is needed to offer all the benefits a Veteran deserves from one of these locations. I am still working with them to clearly define what all is needed in support space for a counselor.	No action required at this time.	Rick Murphy	Veterans Benefits Administration
2	General	VBA: Location in the CBOC is not as critical as I would have guessed. We don't need to be located in the front of the clinic where other critical entities need to be located. VBA would need an entrance close to our offices. It could be located at the back or side of the clinic depending on where our office space would be located. Having a separate entrance would also allow us to do evening programs without requiring the whole clinic be "open" for business.	Concur. Will add in discussion of possible Flex Office occupants.	Rick Murphy	Veterans Benefits Administration
3	General	VBA: The question came up in the prototype meeting I attended about sharing receptionist's responsibilities and greeting VBA customers. This really isn't a huge need on our part. The counselors can usually handle their own receptionist's duties. We're also incorporating a phone system in some of our RO redesigns to allow the Veteran to pick up a phone and be connected to a Counselor or even a Veterans' Service Organization representative located somewhere else in the building.	No action required at this time.	Rick Murphy	Veterans Benefits Administration
4	General	Besides VR&E representatives we also have others in our outbased offices that respond to different needs by the Veteran. I am tracking down how many of those persons exist and how much space they require wherever they are located.	No action required at this time.	Rick Murphy	Veterans Benefits Administration
5	General	Wherever "The VA" is used change to VA.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
6	General	Need to decide on best terminology in lieu of small, medium, & large and explain why.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
7	General	Entry vestibule configuration needs to be consistent in all graphics. Some show rectangular mass, some angled, some bowed.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
8	General	There must be minimal site acreage required for each sized clinic. Might it be worthwhile to include minimal acres/CBOC? As I recall, there was a lot of interest in a 2-story prototype, in spite of certain inefficiencies. It may be useful to address potential site constraints that would require 2-story solutions. I don't believe there is any mention of acreage/prototype. Should there be? If there is need for a clinic in a particular location, and the only sites available are constricted in size, then the prototypes need to be adaptable for vertical solutions.	Nonconcur. Site requirements not in scope of project. Two story options shown for Three PACT CBOC Prototypes.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
9	Section 1	Goals of the project need to be discussed in the Exec. Summary.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
10	Section 1	Exec. Summary should explain some of the challenges: PACT Design Guide has not been published at this time; SEPS has not been updated to reflect space requirements for PACT, etc.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
11	Section 1	Also include in Exec. Summary that the for the purpose of this project we focused on leased clinics that will be constructed as developer design build projects, but that the principles and clinical modules developed should be used for VA owned clinics, and should apply to clinics of all sizes. Projects that will be tenant build out in existing buildings were not addressed, however these designs can be used to help select suitable properties that will best facilitate their use.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)

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12	Section 1	Explain that the scope is limited to developing standard floor plans and does not include the building shell at this point. Once the prototype plans are adopted it may be possible to standardize some structural elements and building systems.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
13	Section 1	Explain the limited scope of mechanical, plumbing, and electrical design under this project.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
14	Section 1	revisions marked on Section 1 PDF and sent to Design Team	Concur. Will revise for next submittal.	Gary Fischer	Office of Construction & Facilities Management (CFM)
15	Section 2	Dental: There is one major error that needs to be amended before this goes forward – You mention that the dental CBOC would have two dentists and two hygienists. It does not include any dental assistants. It would be impossible to run a clinic with two dentists and two RDH without at least 4 dental assistants. That needs to be added to each review of personnel in the document. That will need to be corrected before it goes any further.	Concur. Four dental assistants will be included in the next deliverable.	Dr. Susan Bestgen	VHACO Office of Dentistry, Director of Operations
16	Section 2	Project Narrative, Introduction – It's not necessary to tell VA that we own and operate facilities.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
17	Section 2	Discussion of off-site construction considerations needs to be included in 2.3, structural bay overview.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
18	Section 2	Discuss branding considerations in commons area: entry, check in, etc.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
19	Section 2	Police + Security are located in both Small and Medium clinics; therefore, don't bold in Medium.	Concur. Will revise for next submittal.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
20	Section 2	2nd paragraph – clinic sizes not sized. There are many small edits like this that need to be corrected. (Always cap Veterans.)	Concur. Will revise for next submittal.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
21	Section 2	revisions marked on Section 2 PDF and sent to Design Team	Concur. Will revise for next submittal.	Gary Fischer	Office of Construction & Facilities Management (CFM)
22	Section 2	<ul style="list-style-type: none"> • Small CBOC: <ul style="list-style-type: none"> o 1 eye care provider o 1 eye tech • Medium CBOC: <ul style="list-style-type: none"> o 2 eye care providers, possibly 1 trainee o 2 eye techs • Large CBOC: <ul style="list-style-type: none"> o 4 eye care providers, possibly 2 trainees o 4 eye techs <p>At each of the Prototype CBOCs (Small, Medium and Large), there may be eye care provider training programs, especially for Medium and Large CBOC Prototypes. For planning purposes, there should be 1 additional Eye Exam/Treatment room for each eye care provider trainee (resident/extern/intern).</p> <p>The appropriate sections (3.10 - Small CBOC, page 7; 3.20 - Medium CBOC, page 12; and 3.30 - Large CBOC, page 16) in the Program for Design will need to be revised to include these minimal staffing recommendations.</p>	Possible trainees were accounted for by providing 2.5 exam rooms per provider versus 2 exam rooms.	Dr. Gary Mancil	<p style="text-align: center;">Chief, Optometry Service - Hefner VAMC Eye Clinics Salisbury, Winston-Salem, Charlotte & Hickory - Advanced Low Vision Clinic, VIST & BROS - VISN 6 Tele-Retinal Image Reading Center VISN 6 Optometry Consultant VHA Optometric Services Field Advisory Committee Member</p>
23	Section 2 2.4.5	needs to discuss the optional bay widths for work area and how we arrived at the wider bay. Can't dismiss the differences of opinion. Need to document the decision. Include relationship of work area to outer row of patient encounter rooms and why it's ok that they are not directly off the work area. None of the diagrams in section 2 show the outer row of rooms.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
24	Section 2 2.4.1	None of the diagrams show use for the outboard row of rooms. May be better able to show flow clearly if sheets were less crowded.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)

**VA CBOC Prototype
Progress Submittal**

ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
25	Section 2 Page 2.35	Medium CBOC Prototype - Option A. Plan view and isometric view does not match for PACT + extended team work area and extended teamlet.	Concur. Will revise for next submittal.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
26	Section 2 Page 2.36	Medium CBOC Prototype - Option B. Plan view and isometric view does not match for teamlet 3 & 4 and extended teamlet.	Concur. Will revise for next submittal.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
27	Section 2 Page 2.38	Medium CBOC Prototype - Option D. Plan view and isometric view does not match for teamlet 3 & 4, extended teamlet, PACT + extended team work area.	Concur. Will revise for next submittal.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
28	Section 2 Page 2.9	Structural Bay Overview. Title for top right plan views shows "32' by 36" GRID" should be "32' by 36' GRID"	Concur. Will revise for next submittal.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
29	Section 2.3	Why not show only the recommended 31'10" x 31'10" module? Perhaps this may also provide an opportunity to briefly discuss modular construction, and tie this in throughout the report (if desirable).	Grid discussion is an important part of optimum prototype floor plan. Modular reference will be added to this section.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
30	Section 2.4.1	(blue) 4 + 5 does not look like exam and follow-up occurs in same space; I found these hard to read; numbering (in gold) is off.	Concur. Will revise for next submittal.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
31	Section 2.4.3	Relationship of kiosks to assistance seems problematic in most locations shown.	Nonconcur. Kiosks located in view of reception area and volunteer space. Discussion at charrettes validated location.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
32	Section 3	Eye Clinic: Blind Rehabilitation Counselor (i.e., VIST or BROS) – add "VIST or BROS" to clarify what is meant by "Blind Rehabilitation Counselor" [For reference, the description for Eye Clinic (Large) uses: Office, Blind Rehabilitation (VIST) 120 Counselor]	Concur. Will revise for next submittal.	Dr. Gary Mancil	Chief, Optometry Service - Hefner VAMC Eye Clinics Salisbury, Winston-Salem, Charlotte & Hickory - Advanced Low Vision Clinic, VIST & BROS - VISN 6 Tele-Retinal Image Reading Center VISN 6 Optometry Consultant VHA Optometric Services Field Advisory Committee Member
33	Section 3	Eye Clinic: Office, Chief of Section Service better wording to use "Section Chief" here than to use "Service Chief"	Concur. Will revise for next submittal.	Dr. Gary Mancil	Chief, Optometry Service - Hefner VAMC Eye Clinics Salisbury, Winston-Salem, Charlotte & Hickory - Advanced Low Vision Clinic, VIST & BROS - VISN 6 Tele-Retinal Image Reading Center VISN 6 Optometry Consultant VHA Optometric Services Field Advisory Committee Member
34	Section 3	revisions marked on Section 3 PDF and sent to Design Team	Concur. Will revise for next submittal.	Linda Chan	Office of Construction & Facilities Management (CFM)
35	Section 3	revisions marked on Section 3 PDF and sent to Design Team	Concur. Will revise for next submittal.	Gary Fischer	Office of Construction & Facilities Management (CFM)
36	Section 4	Figure 4.1: Can patient flow be aligned continuously from reception to exam rooms without facing staff flow?	Staff Team Work Area will have control doors. Figure will be revised to reflect most current patient flow through current plans.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
37	Section 4	revisions marked on Section 4 PDF and sent to Design Team	Concur. Will revise for next submittal.	Linda Chan	Office of Construction & Facilities Management (CFM)
38	Section 4	revisions marked on Section 4 PDF and sent to Design Team	Concur. Will revise for next submittal.	Gary Fischer	Office of Construction & Facilities Management (CFM)
39	Section 5	Section 5 needs to be keyed back to section 4 somehow. Make it easy for the reader to relate find the modular parts in the overall floor plan. Consider a key plan or some other road map.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
40	Section 5	Show where a VBA module might be sited and connected to the commons area if they were to be co-located.	Concur. Will revise for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
41	Section 5	Might the large waiting spaces in Medium and Large CBOCs be disorienting for visitors, particularly MH.. I understand combining MH and Primary Care waiting areas so that Veterans are not stigmatized as MH patients, but I would think some MH patients would find a smaller more confined reception space preferable/safer.	Nonconcur. MH subwaiting discussed at Minneapolis charrette. Guidance is to have all waiting combined with ample supervision.	Nancy Sussman	Office of Construction & Facilities Management (CFM)

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
42	Section 5	Table/collaboration space in teamwork areas appears too small in all lay-outs.	Per discussion at Minneapolis charrette, large staff meetings will occur Group Rooms, Shared Medical Appointment Rooms, and Conference Rooms.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
43	Section 5	HBPC: Current building proposal is unacceptable for HBPC team. Due to the nature of our work (30% out in the field, 70% in the clinic) and the need to have a private space for each team member (ongoing health related or social issues related phone conversations with patients, providers etc.; also HBPC PCP needs to have environment free of distractions to be able to focus on important medical issues) we need 4 offices (for 4 team members). We cannot be placed all in the same office. According to the proposed plan, we were offered one 125 sq. feet place.	Plan has been revised to accommodate HBPC in team area, with dedicated storage space, per direction of Sharon Espina.	Jane Balitsky	HBPC Acting Program Manager Maui CBOC
44	Section 5	Suggest to change the design of the building to more contemporary and environmentally sound; current design does not take into consideration climate and landscape of the Island. In order to utilize benefits of natural daylight and save major costs on electricity, the shape of the building needs to be changed to allow for more space with windows. Current literature also supports the idea of benefits of sun light on mood and general health, so having more window space would benefit both, veterans and employees.	Site specific design elements will be included at time of final clinic design, by others.	Jane Balitsky	HBPC Acting Program Manager Maui CBOC
45	Section 5	In the medium & large CBOCs we need to add a storage closet to the Eye Clinic foot print			
46	Section 5	Did not see an Eye clinic showing in the plans for the smaller version CBOC	The Eye Clinic is not included as part of the Small CBOC Prototype. A component has been created for an Eye Clinic for all sizes. At the time of design, the Eye Clinic Component can be used should the workload support the need for inclusion in the Small CBOC by region.	Dr. Gary Mancil	Chief, Optometry Service - Hefner VAMC Eye Clinics Salisbury, Winston-Salem, Charlotte & Hickory - Advanced Low Vision Clinic, VIST & BROS - VISN 6 Tele-Retinal Image Reading Center VISN 6 Optometry Consultant VHA Optometric Services Field Advisory Committee Member
47	Section 5	revisions marked on Section 5 PDF and sent to Design Team	Concur. Will revise for next submittal.	Gary Fischer	Office of Construction & Facilities Management (CFM)
48	Section 5 Page 5.10	Police + Security: Please verify these statements. I believe security falls under police and telecom under IT. While they might share the same room (not preferred) the security system will have a separate enclosed and locked area. I don't think they will be allowed to share the same rack. There is also issue with control of access to these rooms.	Concur. This was confirmed at Minneapolis charrette.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
49	Section 5 Page 5.3	Police + Security: Engineering Assumptions. "Security systems hardware will be housed inside the telecommunications rooms. Security equipment will share space in the telecommunication racks." Please verify these statements. I believe security falls under police and telecom under IT. While they might share the same room (not preferred) the security system will have a separate enclosed and locked area. I don't think they will be allowed to share the same rack. There is also issue with control of access to these rooms.	Concur. This was confirmed at Minneapolis charrette.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
50	Section 5 Page 5.33	Police + Security: Please verify these statements. I believe security falls under police and telecom under IT. While they might share the same room (not preferred) the security system will have a separate enclosed and locked area. I don't think they will be allowed to share the same rack. There is also issue with control of access to these rooms.	Concur. This was confirmed at Minneapolis charrette.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
51	Section 5 Page 5.4	Police + Security: Please verify these statements. I believe security falls under police and telecom under IT. While they might share the same room (not preferred) the security system will have a separate enclosed and locked area. I don't think they will be allowed to share the same rack. There is also issue with control of access to these rooms.	Concur. This was confirmed at Minneapolis charrette.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)

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52	Section 6	Eye Clinic: Equipment modifications for EYOT2, EYVS1, EYVF1, WRC01, EYFD1, WRTM1 (revisions marked up on separate document)	Concur. Will revise for next submittal.	Dr. Gary Mancil	Chief, Optometry Service - Hefner VAMC Eye Clinics Salisbury, Winston-Salem, Charlotte & Hickory - Advanced Low Vision Clinic, VIST & BROS - VISN 6 Tele-Retinal Image Reading Center VISN 6 Optometry Consultant VHA Optometric Services Field Advisory Committee Member
53	Section 6	revisions marked on Section 6 PDF and sent to Design Team	Concur. Will revise for next submittal.	Linda Chan	Office of Construction & Facilities Management (CFM)
54	Section 7	Mental Health: suggest we change the layouts so the patient chair is where the doors are currently and move the door to the other side of the room. As it is, the patient would be sitting mostly behind us if we're working on the computer rather than across from us. By making this switch we can easily look back and forth from the computer to the patient as we work. It also improves safety by increasing "equal" access to the door by the Veteran and the Provider.	Concur. Will revise for next submittal. Intent is for Mental Health patient encounter rooms to be similar to Consult rooms' furniture and equipment layout. Provider work space is provided in teaming areas.	Dr. Maurice Sprenger	VAPIHCS Chief CBOC Mental Health Programs
55	Section 8	Since modular and off-site construction is an integral part of this project, I think the topic should be introduced at the beginning – and then dealt with in detail toward the end, as you've done. There's no context for this topic that all of a sudden appears toward the end.	Concur. Will revise for next submittal.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
56	Section 8	Is modularity and off-site construction considered sufficiently to judge whether designs would be easily standardized? Would it be helpful to have Walden or others review the prototypes?	Section will be developed further.	Nancy Sussman	Office of Construction & Facilities Management (CFM)
57	Section 8 Page 8.2	Modular Structures . "The greatest benefit of using a modular structure from a cost perspective is in the shortened construction schedule." Need to expand on this and point out why the schedule is shortened: <ul style="list-style-type: none"> • site preparation and utility can occur while the prefabricated structures are being built in the factory • the bulk of the construction and finishing work is done indoors so there is less risk of weather-related delays in construction • built on an assembly line that continuously operate • inspectors on site, so the units can be inspected as they are built without having to wait for a city inspector to come and sign off on the work • modular builders take advantage of economies of scale by building multiple similar pieces at once 	Concur. Will revise for next submittal.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
58	Section 8 Page 8.2	"Modular structure construction is better suited to design-build project delivery with a team consisting of manufacturer, architect and general contractor." I don't agree to this statement since we can do this as easily with a design-bid-build project delivery.	Will revise and continue development for next submittal.	Ding Madlansacay	Office of Construction & Facilities Management (CFM)
59	Section 8.2	Off-Site Construction, is unacceptable. Info is most elementary. It doesn't contain anything enlightening relative to application for this project. Transport size diagram actually shows how a module does not work for this layout rather than how it could work. Discuss the drivers for off site prefabrication – schedule and cost, not pre-fab for the sake of pre-fab. Given that, what options are most likely for a design-build lease project? What other strategies might be advantageous in a VA owned project and why? How do to plans you've developed lend themselves to off-site construction? How would building systems be accommodated (penthouses, air distribution)? It's disappointing that this topic has been put off until this late stage rather than integrated into the prototype development. I've brought it up several times, even provided bay dimensions before the Tampa meeting and asked that a grid be overlaid on the plan, but it hasn't happened yet.	Will revise and continue development for next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
60	Section 9	Early in the project we discussed the need to document variations from VA standards. The table should be included as an appendix. Reference to the table should be in the Exec. Summary.	Concur. Will include in next submittal.	Jay Sztuk	Office of Construction & Facilities Management (CFM)
61	Section 9	Cost estimating was deleted from SOW in fee negotiations.	Concur. Will remove section.	Jay Sztuk	Office of Construction & Facilities Management (CFM)

VA CBOC Prototype
Pre-Final Submittal

ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
1	General	Will the three prototypes will include accommodations for Blind Vets (braille signage)?	Specific signage requirements are to be addressed according to VA criteria at the time of design.	Laura Kelly	VISN 21 Planner
2	General	Will Flex Offices be used for multiple purposes to include supervisor functions?	Yes.	Laura Kelly	VISN 21 Planner
3	General	Veterans with Communicable Diseases: Will they be placed in an exam room as close to the check-in to limit disease spread. Negative pressure room.	It was determined that a negative pressure room was not to be included in the prototype early in this study. At the time of design, specific MEP requirements can be addressed as necessary.	Laura Kelly	VISN 21 Planner
4	General	PACT 1 has no radiology.	Correct. In a One-PACT CBOC it was determined that a radiology footprint would not be included in the prototype. Should the workload support inclusion of radiology, a radiology component may be added to a One-PACT CBOC at the time of design.	Dana Sullivan	Asst. Dir. National Radiology Program
5	General	Apparently there will be a common reception area for all patients for all services. This might cause bottlenecks as each service has its own sign-in and processing procedures. This area would need to be large enough to accommodate simultaneous patient arrivals for the multiple different areas.	Yes. The reception area is shared with all the Ancillary Services in that module.	Dana Sullivan	Asst. Dir. National Radiology Program
6	General	Radiology Air Conditioning : Air conditioning support is essential for radiology rooms and the viewing rooms as all of this equipment is digital and operated dependent upon computers. Radiology rooms themselves throw a lot of heat from their electrical cabinets. Viewing rooms and Computerized Radiography systems also have heat components. The air conditioning needs for the radiology suites should be considered separately from the rest of the building.	Specific MEP requirements will be addressed at the time of design.	Dana Sullivan	Asst. Dir. National Radiology Program
7	General	Of course adequate power for the radiography rooms must be planned for.	Specific MEP requirements will be addressed at the time of design.	Dana Sullivan	Asst. Dir. National Radiology Program
8	General	There are challenges in making a galley arrangement work for a dental clinic.	Noted.	Gregory Smith	
9	General	The design of the dental treatment rooms and head set orientation does not accommodate right/left handed providers equally.	Early in the study, it was decided that all patient care rooms are to be right handed.	Gregory Smith	
10	General	The design of the dental clinic offers very little opportunity for natural light which is critical for proper tooth shade matching	Specialized lighting can be provided at the time of design for tooth shade matching.	Gregory Smith	
11	General	All Dentistry Functional Areas should be designed with the same number and type of rooms for both one story and two story layouts.	Concur.	Gregory Smith	
12	Section 1	Refer to item # 5 in Progress Submittal Review. This was not done. Wherever "the VA" is used please change it to "VA".	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
13	Section 1	Please check grammar. Insure punctuation is used correctly.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
14	Section 1	Don't spell out "and" in Construction & Facilities Management	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
15	Section 1	"Project Team" paragraph will read better if you delete "This group has been.....and Three PACT CBOC". It's not good to reference One PACT, Two PACT, Three PACT before you've explained what they are.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
16	Section 1	Move "Challenges" paragraph to the end.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
17	Section 1	First paragraph: Change "It has been identified by VA." to: VA identified that there are potential cost and schedule savings in CBOC facilities with the use of standard design elements and off site construction.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
18	Section 2	<i>Charrettes:</i> aptitude or attitude	Aptitude	Laura Kelly	VISN 21 Planner
19	Section 2	<i>Section 2.4 Conceptual Diagrams - Overview: If you think the initiative will be viewed outside VA, define uniques here as well as in the Appendix.</i>	Noted.	Laura Kelly	VISN 21 Planner
20	Section 2	First paragraph – add open quotation mark before Patient Aligned....	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
21	Section 2	Page 2.4: The last paragraph under PACT Model Overview is an important point. It would help to emphasize it somehow, possibly by repeating it in a highlighted text box.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
22	Section 2	Figure 2.9: Step 7 is not shown on the drawing	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
23	Section 2	Page 2.44: Second paragraph, "module is mirrored...". I don't believe anything is mirrored in this plan. The ancillary services are simply located on the opposite side of the lobby.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
24	Section 2	Page 2.49, Figure 2.28: Vending machines should not back up to glass entry facade.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
25	Section 2	Page 2.63, Figures 2.49 & 2.50: Inconsistent use of Team / Teamlet terminology.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
26	Section 2	Refer to item 23 in Progress Submittal Review. Section 2.9 doesn't say anything about the discussions we had about an 18' bay vs. 31' bay and why we used the wider one.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
27	Section 2 page 2.3, 2 nd paragraph, 3 rd line	Insert "Emergency Department" visits after "fewer" and before "hospital admissions."	Will revise for Final Submittal	Dr. Angie Denietolis	
28	Section 2 page 2.4	Under "Key Principles", "Coordinated", last line should say "clerical associate" instead of "technician"	Changed to Administrative Associate (MHA,PSA,HT) per Dr. Ward Newcomb	Dr. Angie Denietolis	
29	Section 2 2.6	Add a comment in the Project Narrative CBOC page 2.6 ("Scope of Services"): One PACT CBOC includes the following clinical and administrative services: "Eye Clinic, Optional – it may be justified to include eye care"	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
30	Section 2 2.7	In Programming Assumptions, Eye Clinic, add: * One PACT CBOC: (Optional) - 1 provider - 1 tech	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
31	Section 2 2.7	Add a comment in the Project Narrative CBOC Page 7 ("Prototype for Standardized Design..." in the chart on Eye Clinic Programming Assumptions: "One PACT CBOC" - 1 provider - 1 to 2 techs	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
32	Section 2 page 2.3, figure 2.1	4 th stick figure should say "clerical associate", not "technician"	Changed to Administrative Associate (MHA,PSA,HT) per Dr. Ward Newcomb	Dr. Angie Denietolis	
33	Section 2.2, page 2.11	Under Clinic Management for each CBOC there needs to be an office for HAS supervisor	A flex office has been added to the back of the reception area. HAS supervisor may use that space, should a clinic require it.	Dr. Angie Denietolis	
34	Section 2.2, page 2.11	Under Lobby/Common Areas, the One PACT CBOC needs public toilets	Gang toilets are included in the Two-PACT and Three-PACT prototypes only. The One-PACT prototypes includes toilets within the PACT module.	Dr. Angie Denietolis	
35	Section 2.2, page 2.2, "Staff with Patient"	Numbers 2-5 should say "LVN" instead of "RN." Number 6 can remain RN.	Concur. Will revise for Final Submittal.	Dr. Angie Denietolis	

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
36	Section 2.2, page 2.5, 4 th bullet under "population", second line	Should say "8 teamlets" in parentheses to be consistent with definition.	Concur. Will revise for Final Submittal.	Dr. Angie Denietolis	
37	Section 2.2, page 2.5, 5 th bullet under "population"	Should say "12 teamlets" in parentheses	Concur. Will revise for Final Submittal.	Dr. Angie Denietolis	
38	Section 2.2, page 2.6	Under "Scope of Services" should add "Telehealth" to each size of CBOC	Telehealth services is included within the PACT Space Planning Module. It is not a separate line item in the PFD.	Dr. Angie Denietolis	
39	Section 2.2, starting on page 2.21, then 2.31, then 2.33	Number two on these types of visits needs to say "information sheet" instead of "yellow sheet". Yellow sheet is a local term in Tampa and would be confusing to the field. There could be others that I missed.	Concur. Will revise for Final Submittal.	Dr. Angie Denietolis	
40	Section 3 3.11	Insert after page 11, Functional Area (Optional): Eye Care EYOT2 1 0 Exam/Treatment Room 2 125 250 WRC01 1 0 Waiting Area (Dilation) 1 60 60 EYVS1 1 0 Photography/Imaging Room 1 180 180 EYVS1 1 0 Pre-Testing Room 1 125 125 EYVF1 1 0 Visual Fields Room 1 125 125 SRE01 1 0 Storage Room 1 100 100 Net Area: 840	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
41	Section 3 3.13	Add SRE01 "Storage Room" 100 unit area to page 13, VA CBOC (Two PACT) Functional Area 9	Storage room is shared with other ancillary services. If additional storage is needed, a flex office could be used for that purpose	John Townsend	
42	Section 3 3.18	Add SRE01 "Storage Room" 100 unit area to page 18, VA CBOC (Three PACT) Functional Area 11 – Eye Clinic	Storage room is shared with other ancillary services. If additional storage is needed, a flex office could be used for that purpose	John Townsend	
43	Section 3 3.3	In VA CBOC PROTOTYPE (One PACT) chart, add: Eye Clinic (Optional) with PFD Net Area and PFD Gross Area Will also need to add EYE CLINIC Functional Area PFD info.	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
44	Section 3 3.3	3.1 CBOC Prototype: One PACT Program for Design On Page 3 add a comment after Canteen – "Eye Clinic Optional" – it may be justified to include Eye Clinic	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
45	Section 4	Page 4.4: Vestibule design doesn't address 2 main concerns that were brought up: - Direct air path. Offset of doors shown is too little to be effective. - Location of wheelchairs. Wall creates a narrow channel much longer than it needs to be and difficult to get in and out of.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
46	Section 4	Page 4.4: Narrative says vestibule is 15' deep, however dimensions on page 8.11 show entry module as only 13' overall with about a 2' inset at the vestibule, which would make it roughly 10' inside. There's still some inconsistency in the drawings with some showing the interior vestibule wall inset and some showing it in line with the security office. Example: figures 4.2 & 5.2.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
47	Section 4	Radiology: Supply/utility for Clean and soiled linens, general supplies and room accessories; gowns and robes for patients.	Storage room is shared with other ancillary services. If additional storage is needed, a flex office could be used for that purpose	Dana Sullivan	Asst. Dir. National Radiology Program
48	Section 4	Ultrasound : Is there a sub waiting room for these patients ? There should be more than one dressing room, one for male and female dressing room. These patients will most likely be mixed gender Clean and soiled utility room. Supply room for ultrasound gels etc.	Early in the study, the understanding was that a sub-waiting area was not required. Family members and patients will utilize the lobby/commons area instead of a sub-waiting area	Dana Sullivan	Asst. Dir. National Radiology Program
49	Section 4	Break room/locker rooms/ conference area for Radiology Staff	These functions are shared with other services in the ancillary services diagnostic module	Dana Sullivan	Asst. Dir. National Radiology Program
50	Section 4	Staff Bathrooms	Staff toilets are located and shared in the ancillary services diagnostic module	Dana Sullivan	Asst. Dir. National Radiology Program

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
51	Section 4	Dressing rooms and bathrooms must accommodate wheelchairs.	Concur. All layouts comply with ABA accessibility codes	Dana Sullivan	Asst. Dir. National Radiology Program
52	Section 4	I think tis a good idea to have a mobile pad as I am sure in a PACT III at least CT will be required.	Concur.	Dana Sullivan	Asst. Dir. National Radiology Program
53	Section 4	PACT III : Supply/Utility area (locked and unlocked) for contrast materials. Barium etc. and Mixing of material for fluoroscopic exams.	A stainless steel sink and counter is provided outside of the radiography rooms for mixing of materials.	Dana Sullivan	Asst. Dir. National Radiology Program
54	Section 4	Same as the above comments but with the added supply/utility area for contrast materials.	A stainless steel sink and counter is provided outside of the radiography rooms for mixing of materials.	Dana Sullivan	Asst. Dir. National Radiology Program
55	Section 4 4.2	After Eye Clinic - One PACT CBOC Prototype paragraph, add: Refer to Section - 5 Proposed Prototype Layouts for additional information.	Non-concur. The eye clinic is not included in the One-PACT CBOC Prototype	John Townsend	
56	Section 4 Page 17 Planning Components	Under the heading 'The Components included in this section are:' change 'Dental' to 'Dentistry'	Concur. Will revise for Final Submittal.	Gregory Smith	
57	Section 4 Page 35 Planning Components	Change the page heading from, 'Dental - Three PACT CBOC Prototype' to 'Dentistry - Three PACT CBOC Prototype.' Make the same change for the title beneath Figure 4.60	Concur. Will revise for Final Submittal.	Gregory Smith	
58	Section 4 Page 4.33	Please clarify what is a "Cone Densitometer?"	Bone Densitometer. Will revise for Final Submittal.	Dana Sullivan	Asst. Dir. National Radiology Program
59	Section 5	Three PACT Prototype: Some of the offices are still 120SF versus 125SF 8 - CLINIC MANAGEMENT OFA02 1 0 Office, CMO 1 120 120 OFA02 1 0 Office, Nurse Manager 1 120 120 19 - MULTI-SPECIALTY CARE / ANCILLARY DIAGNOSTIC SERVICES EXP01 1 0 FA2: Podiatry Exam Room 1 120 120 WRTM2 1 0 FA2: Tele-Health Room 1 120 120 Comment: Tele-Derm OFDR1 1 0 Shared Office, Tech 1 120 120	Concur. Will revise for Final Submittal.	Tim Bertucco	VISN 21 Deputy Capital Asset Manager
60	Section 5	On each of the prosed layout drawings indicate the net usable SF and building gross SF.	Noted. Will include in the Final Submittal.	Jay Sztuk	Construction & Facilities Management
61	Section 5	Please add grid line numbers/letters to help in relating one drawing to another.	Noted. Will include in the Final Submittal.	Jay Sztuk	Construction & Facilities Management
62	Section 5	Area division lines don't agree between the overall drawings and larger scale drawings. Example: figures 5.4 & 5.5. Check all sheets and make sure the lines agree.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
63	Section 5	Figures 5.5 & 5.6: Wouldn't it make more sense to move the cut line between areas A & B to the right to include all of the clinical space in area A? There's enough room on the sheet.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
64	Section 5	Figure 5.12: front wall of entry module is cut off.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
65	Section 5	Figures 5.17 & 5.18: division between areas A & B is unfortunate. If the line were moved down 4' you would see the entire wing PACT block in area A. Please review the cut lines on all of the drawings and make sure they are in the optimal locations.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
66	Section 5	Figures 5.22 & 5.24: Upper part of plans are cut off.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
67	Section 5	Figure 5.37: Similar to 5.35. Showing the entire occupied area on one sheet would be more beneficial than dividing the plan just to fit the roof in.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
68	Section 5	Figures 5.40 through 5.49: Key plans don't match footprint.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
69	Section 5	Figures 5.46 through 5.49: Drawing labeled Area F is actually Area G and drawing labeled Area G shows Area F. Reconsider how these are broken up. They can be on 2 sheets instead of 4. The roof area can be cut off.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
70	Section 5	Components overviews, figures 5.1, 5.3, 5.9, etc: These become progressively more difficult to decipher, with 5.20 making your eyes cross and head hurt. Please reconsider how you want to convey this info graphically.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
71	Section 5	Figure 5.35: This plan of area F shows all of area E, so why have 2 separate plans?	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
72	Section 5 Page 103 Proposed Layouts CBOC Pre-Final	The storage room needs to be added to the dental clinic. Switching the locations of the x-ray and clean cart rooms would place imaging closer to the dental treatment rooms which is preferable.	Storage room is included within the dental footprint. Switching the x-ray and clean room is problematic as the x-ray room is larger than the 125 SF universal room	Gregory Smith	
73	Section 5 Page 99 Proposed Layouts CBOC	Change 'Dental' to 'Dentistry' on the Two Story Modified Layout, Component Overview - Second Floor	Noted. Will include in the Final Submittal.	Gregory Smith	
74	Section 5 5.5	In Figure 5.1, please add layout for EYE CLINIC (Optional).	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
75	Section 5 5.7	In Figure 5.2, please add layout for EYE CLINIC (Optional).	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
76	Section 5 Page 5.63	Layout – These patients are going to be walking forever to get from the vestibule to whatever service. I note that in this layout there is a door off of radiology going out to a "mobile pad", it would be very efficient and reduce the patient's lengthy walking; if they could establish a reception right there for the Radiology patients.	All patients will enter the clinic through the vestibule into the lobby/commons area. A separate Radiology entrance is not included as part of the prototype	Dana Sullivan	Asst. Dir. National Radiology Program
77	Section 5 Page 73 Proposed Layouts CBOC Pre-Final	Change 'Dental' to 'Dentistry' on the Two Story Layout, Component Overview - Second Floor	Noted. Will include in the Final Submittal.	Gregory Smith	
78	Section 5 Page 77 Proposed Layout CBOC Pre-Final	The soiled cart room needs to be added to the dental clinic design for the two story layout with the dental clinic on the second floor. Switching the locations of the x-ray and clean cart rooms would place imaging closer to the dental treatment rooms which is preferable.	Storage room is included within the dental footprint. Switching the x-ray and clean room is problematic as the x-ray room is larger than the 125 SF universal room	Gregory Smith	
79	Section 6	Room configuration also considered staff safety	Noted.	Laura Kelly	VISN 21 Planner
80	Section 6	My comment is that the equipment rooms look right but the support space is small. No reception/scheduling, storage, too few offices. And I assume that conference rooms, biomed, IT and utility spaces, break room will be elsewhere?	Support spaces are to be shared with other services in the Ancillary Services Diagnostic Module	Charles Anderson	Chief Consultant, Diagnostic Services
81	Section 6	All Exam Rooms: At the Palo Alto mock-up the preferred location of the specialty cart was below the counter on the end closest to the door. The sink moved to the opposite end of counter. Is there a reason not to do that here?	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
82	Section 6	See comments in Section 5.0 regarding divisions used for enlarged plans.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management

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ITEM NO.	Page Number (x.xx)	REVIEW COMMENTS	RESPONSE (by Contractor)	Reviewer	Department
83	Section 6 Pages 362/474 Equipment lists	Only one computer workstation is in each dental treatment room. You should have two - one for chart/reference to CPRS and Dental Record manager, one other one for imaging (could be dedicated to obtaining and viewing imaging). It is likely that one would want both the radiographs and the chart up at the same time during dental treatment. The computer workstation should be positioned so that either the doctor or the tech/assistant can enter data - during an exam, the assistant may chart for the doctor, off the visible images and the clinical exam. Please let me know if further explanation is needed.	Noted. Will add a second computer workstation in the Final Submittal.	Dr. Susan Bestgen	Office of Dentistry
84	Section 6 6.13	In Section 6.2, need to add EYE CLINIC (Optional) for VA CBOC One PACT Prototype in Figure 6.9, Equipment Layout. Will also need to add EYE CLINIC Functional Area PFD info.	In a One-PACT CBOC it was determined that an eye clinic footprint would not be included in the prototype. Should the workload support inclusion of an eye clinic, a component may be added to a One-PACT CBOC at the time of design.	John Townsend	
85	Section 6 Pages 362-376 Equipment Layouts, General Comment	Change the name of Functional Area from 'Dental' to 'Dentistry' in all locations throughout the documents	Noted. Will revise for Final Submittal	Gregory Smith	
86	Section 7	See comments in Section 5.0 regarding divisions used for enlarged plans.	Concur. Will revise for Final Submittal.	Jay Sztuk	Construction & Facilities Management
87	Section 8	Pages 8.1 through 8.4 are a primer on off-site construction. The report should tell us what method or methods could be most realistically used in the type of projects we are addressing, design/build lease projects. Those strategies would be the ones that could give the developer a competitive edge by reducing his cost or delivery time. The report should then focus on those most advantageous strategies and discuss how the prototypes can facilitate them.	Noted. Will revise for Final Submittal	Jay Sztuk	Construction & Facilities Management
88	Section 8	Page 8.11: Figure 8.8 shows one possible module layout. I think for most it would be an unacceptable one, having columns at 10'-5" on center in the team work area and a column in the shared medical appointment room. It's unfortunate that we haven't seen any attempt at overlaying a modular building grid on the plans until the pre-final submission, and what we're seeing now doesn't work very well.	Noted. Will revise for Final Submittal	Jay Sztuk	Construction & Facilities Management
89	Section 8	Include feedback on the design that you received from the modular building providers consulted.	Noted. Will revise for Final Submittal	Jay Sztuk	Construction & Facilities Management

10.2 Meeting Minutes

Meeting Minutes and related documents from the following site visits and meetings can be found on the following pages:

- Project Kick-off Meeting
21 August 2013
- VISN 21 Kick-off Meeting and Site Visit
17-18 September 2013
- Bi-weekly Conference Call #1
24 September 2013
- VISN 23 Kick-off Meeting and Site Visit
25-26 September 2013
- VISN 8 Kick-off Meeting and Site Visit
2-3 October 2013
- Bi-weekly Conference Call #2
8 October 2013
- Space Programming Meeting - CFM
10 October 2013
- CBOC Prototype Space Programming Charrette
17 October 2013
- Bi-weekly Conference Call #3
22 October 2013
- Space Programming Meeting - Canteen
30 October 2013
- Bi-weekly Conference Call #4
5 November 2013
- CBOC Prototype Charrette - DC
13-14 November 2013
- Bi-weekly Conference Call #5
19 November 2013
- Space Programming Meeting - Integrated Mental Health
21 November 2013
- Space Programming Meeting - Women's Health
3 December 2013
- Bi-weekly Conference Call #6
4 December 2013
- Space Programming Meeting - General Mental Health
21 November 2013
- Space Programming Meeting - Women's Health
6 December 2013
- CBOC Prototype Charrette - Mare Island
10 -11 December 2013
- Space Programming Meeting - Dental
17 December 2013
- Bi-weekly Conference Call #7
19 December 2013
- Space Programming Meeting - Radiology
6 January 2014
- Bi-weekly Conference Call #8
7 January 2014
- Maui Test-Fit Follow-up
8 January 2014
- Space Programming Meeting - Optometry
10 January 2014
- CBOC Prototype Charrette - Tampa
14 - 16 January 2014
- Space Programming Meeting - Audiology
15 January 2014
- Bi-weekly Conference Call #9
28 January 2014
- Space Programming Meeting - Police + Security
29 January 2014
- Space Programming Meeting - Logistics
4 February 2014
- CBOC Prototype Charrette - Minneapolis
11 - 13 February 2014

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- Rapid City Test-Fit Follow-up
24 February 2014
 - Bi-weekly Conference Call #10
25 February 2014
 - Typical Exam Room Layout - Follow-up
25 February 2014
 - Space Programming Women's Health - Follow-up
26 February 2014
 - Rapid City Test-Fit Revisions Follow-up
28 February 2013
 - Bi-weekly Conference Call #11
11 March 2014
 - CBOC Final Presentation - Washington DC
25 March 2014
 - Space Programming Radiology - Follow-up
27 March 2014

PROJECT: 28319.000

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	August 23, 2013
Meeting Date	August 21, 2013
Location	SmithGroupJJR Office, 901 K Street NW, Suite 400, Washington, DC 20001
Time	1000 - 1530
Purpose	Kick-off Meeting

PARTICIPANT	COMPANY	PHONE	EMAIL
See attached scan for attendees			
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.Sztuk@va.gov
Peter Yakowicz	VA VISN 23, Capital Asset Manager	651-405-5633	peter.yakowicz@va.gov
Fei(Linda) Chan	VACO CFM, Planner/Architect	202-632-4781	Linda.chan@va.gov
Alejandra De La Torre	VA CFM Architect, Facility Standards Service	202-632-4838	alejandra.delatorre@va.gov
Ward Newcomb	PCS, 10P4F, PACT Space	334-221-5353	William.newcomb@va.gov
Lloyd H. Siegel	VA CFM	202-632-4632	
Donald L. Myers	VA CFM	202-632-5388	donald.myers@va.gov
Bill Kline	SmithGroupJJR, Studio Leader	202-974-0794	Bill.Kline@smithgroupjjr.com
Christopher Arnold	SmithGroupJJR, Project Manager	202-974-4537	Christopher.Arnold@smithgroupjjr.com
Tracy Bond	SmithGroupJJR, Senior Medical Planner	202-974-5161	Tracy.Bond@smithgroupjjr.com
Emily Dickinson	SmithGroupJJR, Medical Planner/Architect	202-974-4586	Emily.Dickinson@smithgroupjjr.com
Echo Jiang	SmithGroupJJR, Architect	202-974-4505	Echo.Jiang@smithgroupjjr.com
Kelly Soh	Innova, Healthcare Planner	703-842-4339	Kelly.soh@theinnovagroup.com

The following attended via phone:

Angie Denietolis	Tampa VA		
Gabryela Passeto	SmithGroupJJR, Architect/Medical Planner	202-974-0830	Gabryela.passeto@smithgroupjjr.com
Michael Hartley	VISN 8		
Mike R			
Caitlin Cunningham	VA Real Property		Caitlin.cunningham@va.gov
See attached scan for attendees			

ITEM	DISCUSSION	ACTION
	<i>The following are the morning discussions:</i>	
1.0	Bill Kline welcomed the attendees and introduced the project team (Project Manager: Christopher Arnold; Tracy Bond – Lead medical planner) as well as briefly introduced team’s working experience on Navy Medicine Patient Centered Medical Home (PCMH) studies and other naval projects from macro to micro level.	
1.1	Introductions were made around the table and phone.	
1.2	Tracy Bond explained the purpose of this kick-off meeting is to engage the leadership, to organize the team and to begin the work. The goal is to make collaborative discussion.	
2.0	Jay Sztuk explained that this project stems from observations made while estimating leased CBOCs. Each project design started “from scratch” and VACO has not been able to successfully standardize.	
2.1	The road to this project started as a submission to the VA Innovation Program. The first phase was a feasibility study aimed at identifying the best approach for standardization. Due to the wide range of facility sizes within VA it was determined that development of a modular kit of parts would have the best chance of success.	

2.2	Now the goal is to develop the prototypes. SmithGroupJJR was selected and has recently completed a similar project for the Navy.	
2.3	The best chance for success of a CBOC prototype that implements PACT is local buy-in to the concepts. Three VISNs are involved and will represent three projects at different sizes. This will show the prototype translated through larger sizes.	
2.4	Dr. Ward Newcomb explained that VHA is a long-term preventive health care HMO that plans like a fee-for-service. The lack of standardization has to do with resources: proximity to medical schools, geographic location, staff availability, etc.	
2.5	Ms. Bond emphasized that this is a holistic team project and the team includes everyone in the room.	
3.0	A few recent SmithGroupJJR projects were presented to give background to the work at hand and spur discussion.	
3.1	The Southern California Market Area Analysis is an ongoing Health Care Requirements Analysis (HCRA), Market Area Analysis, Space Assessment, and Course of Action recommendation for Naval Medicine in Southern California. <ul style="list-style-type: none"> Population informs Workload, Workload informs Staffing, and Staffing informs Space. The CBOC project does not include the HCRA process, so the team will have to rely on previous studies and data to determine space needs and inform planning. The most often-occurring size clinics are hard to determine. This study should focus on the standard PACT team, with different specialists. 	
3.2	A point of discussion is how big the team can get while staying patient-focused and efficient.	
3.3	The Patient Centered Medical Home Port was a study for Navy Medicine programming and designing templates for three sizes of clinics achieving the PCMH concept (as defined by the Joint Principles).	
3.4	The team POD (shared workspace) presents generational and cultural issues regarding privacy and hierarchy. <ul style="list-style-type: none"> Is the office a recruitment tool? Or is it an outdated status symbol? The care model is a staff recruitment tool. 	
3.5	Family members are an important part of the care team.	
3.6	Education spaces are also important in VA clinics.	
4.0	Kelly Soh explained the differences between Department of Defense (DoD) and VA definitions regarding "continuity of care." <ul style="list-style-type: none"> In DoD, seeing a member of your team is considered continuity. In VA, there is a large number of part-time providers and the RN care manager provides continuity. Continuity is probably best at the CBOC level. Angie Denietolis explained there is good continuity of care and scheduling can solve several issues. 	
5.0	VA CBOC Guidelines need to have clear area definitions up front in the study. DGSF (department gross square feet) translates to rentable square feet. Designers often talk in BGSF (building gross square feet). <ul style="list-style-type: none"> VA net-to-department grossing factor is 1.5 (formerly 1.65). DGSF to BGSF factor is 1.35 The maximum BGSF is 1.9 times the department net. 	
5.1	Each team will equal a module. Team is a measure of staff and module is a measure of space.	
5.2	The desire is that all the rooms will be the same: same-handed, all have sinks, resilient flooring, etc. <ul style="list-style-type: none"> Furniture will be different per function. Hand sanitizers are effective, but sink is still necessary. It is important that the patient sees the provider wash his hands. The provider is never to have his back to the patient. 	

5.3	<p>There is an ongoing discussion regarding the operational issue of bringing the provider to the patient or the patient to the provider.</p> <ul style="list-style-type: none"> • There are security issues with computer logon; each provider has to log in/out each time he enters/leaves a room. • Typically, the majority of the exam visit is with the patient sits in a chair, not on an exam table. The provider and patient may move to a consult room if they require a longer conversation. • The room is broken into the “consultation zone” and the “exam zone.” • There is a large focus on chronic disease management with a small clinical portion. This care lends itself to the consultation zone of the room. The exam on the table is still an important even though it may account for a small percentage of time spent in the exam room. Tampa has even been using exam tables with arm support that can transition to comfortable chairs. 	
5.4	<p>The providers use tablets. However, they still need computers and screens for typing and visibility. Docking stations could be used as an alternate solution.</p>	
	<p><i>The following are the afternoon discussions:</i></p>	
6.0	<p>There are concurrent efforts currently regarding the PACT and its design implications. There is a PACT Design Guide in development that is different from the CBOC Design Guide. The July 2013 PACT Guide is to govern over the CBOC Guide.</p>	
7.0	<p>All three VISNs will participate in the planning of the prototypes and example clinics. The team will start with generic programs and add in specifics. The basics need to be understood before adapting to unique situations.</p> <ul style="list-style-type: none"> • The “universal” parts of the clinic need to be identified. The NIBS study should be used for reference. Not everything is logical (for instance, rural clinics’ unique staffing issues). • There will be a kit of parts and the three projects will show the execution of the kit of parts. 	
7.1	<p>VISN 8 clinic will most likely be Brooksville.</p>	
8.0	<p>The team will have to assume that clinical planning assumptions are correct in workload for ancillary services. Follow each specialty’s Space Planning Criteria.</p> <ul style="list-style-type: none"> • SEPS is a planning tool based on Space Planning Criteria, which is based on data and evidence. Team should build on this data and explain process. 	
8.1	<p>Space can be the transformational lever to implement organizational change.</p> <ul style="list-style-type: none"> • There is a misconception that if the product/process is better, it must be more expensive and take more space. • Ideally, the care model will sell itself. 	
9.0	<p>The next step is a round of site visits and meetings at each VISN.</p> <ul style="list-style-type: none"> • VISN 21 – 16-20 September • VISN 23 – 25-27 September • VISN 8 – 2-3 October • Each visit will be preceded by a conference call. • A data request will be sent prior. The facility and VISN planner should be at the meeting. 	
9.1	<p>The first charrette will focus on developing the base module and include service line chiefs.</p> <ul style="list-style-type: none"> • The first charrette is proposed for 13-14 November in Minneapolis • The second charrette is proposed for 10-11 December in San Francisco • The third charrette is proposed for 14-15 January in Tampa • Each charrette will be two full days 	
9.2	<p>Ms. Bond proposed an update call every two weeks with this steering committee. The group discussed 2:00 Eastern, every other Tuesday. The first call will be scheduled for Tuesday September 24th prior to the second site visit due to scheduling conflicts and the duration of the first site visit with travel.</p>	

END OF MINUTES - IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE TRACY BOND AT 202-974-5161 tracy.bond@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.



Prototype for Standardized Design and Construction of Community Based Outpatient Clinics

Kick-Off Meeting

LOCATION: SmithGroupJJR Office, 901 K Street NW, Suite 400, Washington, DC 20001

DATE: 08/21/2013

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 27 September 2013
 Meeting Date 17-18 September 2013
 Location Tripler Army Medical Center
 Purpose Kick – off Meeting

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ITEM DISCUSSION ACTION

17 September 2013

1.0 VA CBOC Leeward Tour – 1300

Attendees: Dr. Curtis Nakatsu, Craig Oswald, Timothy Bertucco, Tommy Driscal, Larry Janes, Jay Sztuk, Linda Chan, Dr. Ward Newcomb, Tracy Bond, Gabryela Passeto, and Chris Phillips

- 1.1 Craig Oswald gave a brief introduction about the Leeward Clinic prior to the walk-thru:
- The Leeward Clinic is in a leased medical office building renovated in 2012.
 - The clinic is located on the 5th floor occupying 7,000 S.F. and costs approximately \$300K to operate annually.
- 1.2 There are 21,000 veterans in Oahu – 7,000 of those veterans reside in the Ewa Plains.
- 1.3 Tripler Army Medical Center is the main hub with 7 CBOCs and 3 outreach programs with collaborative efforts. Of the 7 CBOCs, 6 are in leased MOB's with the exception of the stand-alone clinic in Guam.

- 1.4 Dr. Curtis Nakatsu escorted the team throughout the clinic. See attached floor plan for walk-thru notes and observations.
- 1.5 Leeward Clinic has two PACT Teamlets but is considering moving to a third. They are currently seeing about 1,300 unique patients out of the 7,000 veterans that reside on this side of the island.
- 2.0 Ambulatory Care Center Tour – 1445**
Attendees: Dr. Marianne Antonelli, Craig Oswald, Timothy Bertucco, Tommy Driscall, Larry Janes, Jay Sztuk, Linda Chan, Dr. Ward Newcomb, Tracy Bond, Gabryela Passeto, and Chris Phillips
- 2.1 Dr. Antonelli gave a brief introduction about the Ambulatory Care Center prior to the walk-thru:
- Three story clinic with 3 primary care modules and 1 specialty care module
 - Mental health is isolated and located on the first floor of the clinic
 - Primary care, women's health, optometry, pathology, and radiology are located on the second floor of the clinic
 - Dental, GI Suite and administrative offices are located on the third floor of the clinic
 - Approximately 50,000 SF of space deficiency within this building
 - This clinic supports an enrolled population of approx. 23,000; unique users are approx. 9,000.
 - 1 exam room per provider, also used as their private office
 - Mental health has extended service hours on Tuesday evenings
 - Primary Care has extended service hours on Saturdays and is utilized well
 - Ancillary services do not currently offer extended hours
 - The women's clinic does not offer extended hours due to staffing. No mammography is provided at the clinic.
 - Dr. Antonelli feels that Women's Health should have a separate entrance. Current female veteran population must pass through lobbies and waiting space with male veterans.
- 2.2 Dr. Marianne Antonelli escorted the team throughout the clinic. See attached floor plans for walk-thru notes and observations.

18 September 2013

3.0 Kick-off Meeting

Attendees: Dr. Bernstein, Dr. Spenger, Dr. Stack, Sharon Espina, Craig Oswald, Timothy Bertucco, Tommy Driskill, Larry Janes, Mark Fienhold, Jay Sztuk, Linda Chan, Dr. Ward Newcomb, Tracy Bond, Gabryela Passeto, and Chris Phillips

- 3.1 Jay Sztuk explained that this project stems from observations made while estimating leased CBOCs. Each project design started "from scratch" and VACO has not been able to successfully standardize. He also gave a brief timeline of the project and emphasized the purpose is not to think in terms of "my clinic/their clinic" but "our clinics", with all participants contributing to the design decisions for each location.
- The road to this project started as a submission to the VA Innovation Program. The first phase was a feasibility study aimed at identifying the best approach for standardization. Due to the wide range of facility sizes within VA it was determined that development of a modular kit of parts would have the best chance of success.
 - Now the goal is to develop the prototypes. SmithGroupJJR was selected and has recently completed a similar project for the Navy.
 - The best chance for success of a CBOC prototype that implements PACT is local buy-in to the concepts. Three VISNs are involved and will represent three projects at different sizes. This will show the prototype translated through larger sizes.
- 3.2 Tracy Bond welcomed the attendees and explained the purpose of this kick-off meeting is to engage the leadership, to organize the team and to begin the work. She briefly introduced the team's working experience on Navy Medicine Patient Centered Medical Home (PCMH) studies and other naval projects from macro to micro level. The goal is to make collaborative discussion and emphasized that this is a holistic team project and the team includes everyone in the room.

- 3.3 Jay stated that for the purposes of this study, new construction is the direction, but will have to be adaptable for leased spaces with modifications. Maui will be a stand-alone construction clinic.
- Mark Fienhold stated he is concerned with the sizes tagged with a small clinic. A 20,000 SF clinic is impossible to come by in Hawaii, especially in this funding environment.
 - Having a basic facility that can be built in the minor funding threshold is critical
 - Hawaii and surrounding islands have an approximate \$1,000 per square foot of construction costs. This is a tough task because property management does not consider geographic location when funding is concerned.

4.0 Space Requirements – Small Clinic - Single PACT Module

- 4.1 3 teamlets currently programmed for primary care and 1 teamlet for specialty care
- 4.2 Minimum 1 isolation room with dedicated patient toilet
- 4.3 Large number of visiting specialty providers will need hoteling space or POD
- 4.4 Consider multiple use and capability “universal” rooms versus additional program specific spaces

Scope of Services

5.0 Mental Health – Dr. Maurice Sprenger

- 5.1 The vision for Mental Health is to continue care integration with Primary Care to keep from stigmatizing veterans
- BHIP – Behavioral Health Integrated Program is an initiative within PACT to treat an entire empanelment of patients.
- 5.2 Sharon Espina emphasized “Warm hand-off” approach when we move away from the provider office/exam/treatment combined room. The focus is still to be “patient-centered”.
- 5.3 Consult rooms with touchdown space are required for providers that are on the field seeing patients. They will still need a space within the clinic for documentation.

6.0 Tele-Health/Tele-Medicine

- 6.1 Tommy Driskill stated Tele-health is the direction care is going, it should be programmed and it is equipment driven and a fit out should be designed.
- Dr. Ward Newcomb asked everyone to consider how tele-health is defined. Is it a laptop with a camera or a \$20,000 piece of equipment? Universal flexibility is critical. What is the difference between V-Tel and Tele-Health?
 - Sharon Espina confirmed tele-health is widely used, especially due to the remoteness of the islands and specialists located off-site.
 - Discussion ensued on bringing fiber to every room for maximum flexibility to allow for tele-health capability through-out the clinics.
- 6.2 Craig Oswald informed attendees that the VA Pacific Islands Healthcare System Home Tele-health (HT) program in Guam is the fastest growing initiative.

7.0 Specialty Care – Dr. Richard Stack

- 7.1 Dr. Richard Stack explained demand is such that two specialists would be sent to any given CBOC each day if space were available to accommodate them.
- Currently, only 1 exam room is available and specialty care service rotates on any given day. The demand is there to eventually fill the module.
 - Ideally, there would be 4 exam rooms and a consult room dedicated to Specialty Care.
 - A specialty RN and LVN would be required to successfully implement the services at each clinic for coordinating patients. The reception staff is overloaded and if they have to support a visiting specialist, their work falls behind
- 7.2 Optometry – Provide 1 eye lane in each CBOC location
- 7.3 Audiology – Not critical in every CBOC. This service would have to be very selective based on demand.

- 7.4 Dermatology – Universal minor procedure room?
- 7.5 Laboratory – Point of Care Testing (POCT) should be the norm in the Small and Medium CBOCs. A Large CBOC would be the first instance that a Chemistry section may be seen.
- 7.6 Home Based Primary Care (HBPC) – Could be included in any CBOC. Staffing number is specific to that area.
- 7.7 Pharmacy – Currently provide, not dispense. ADDs room with service window and consult room for clinical pharmacist required. No dispensing medications out of the Automated Dispensing Device (ADDs) machine.
- 7.8 Women's Health – Integrated within the PACT Module for a small CBOC

8.0 Veteran's Benefit Administration (VBA)

- 8.1 Craig Oswald stated their model is to have a VBA presence in all their clinics as much as possible.
 - A clinics colocation to a vet center, office of veterans is truly patient-centered and should be considered (May want to re-word this for clarity). A "warm hand-off" can be provided if they are collocated in the event of a veteran crisis.
- 8.2 Tommy Driskill stated the clinic staff is not educated for VBA questions.
 - Jay Sztuk suggested designing a plug in module for VBA should be considered with tele-conferencing capabilities as well.
 - Tommy Driskill added that alternatives should be considered so that only actual remote locations implement VBA rather than apply to all clinics where access is not problematic.

9.0 Next Steps

- 9.1 Continue to kick-off the meetings at the remaining VISNs:
 - VISN 23 – 25-27 September (Minneapolis, MN)
 - VISN 8 – 2-3 October (Tampa, FL)
- 9.2 Bi-weekly calls to provide a project update will be held starting 24 September 2013.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

- 1.2 Tracy Bond welcomed the attendees and explained the purpose of this kick-off meeting is to engage the leadership, to organize the team and to begin the work. She briefly introduced the team's working experience on Navy Medicine Patient Centered Medical Home (PCMH) studies and other naval projects from macro to micro level. The goal is to make collaborative discussion and emphasized that this is a holistic team project and the team includes everyone in the room.
- 1.3 Jay stated that for the purposes of this study, new construction is the direction, but will have to be adaptable for leased spaces with modifications.
- 1.4 Pete Yakowicz explains how VISN 23 is very rural. The VISN has 68 CBOCs and it still isn't enough to serve the patient population. In some cases, the CBOCs house functions that don't necessarily belong in their clinics, but tends to be strategically placed there as a means to be centrally located between larger medical centers.
- 1.5 Chris Phillips summarized the highlights of the VISN 21 Kick-off Meeting:
- Current Maui CBOC has 3 teamlets
 - Small CBOC Prototype should include at least one PACT Module (4 teamlets)
 - Specialty services are provided by visiting specialty providers
 - Will space be provided to include VBA?
 - This is important for CBOCs that are very remote
 - Tele-Health/Tele-Medicine must be addressed
 - Discussion ensued on including fiber to every room to accommodate any future bandwidth requirements
 - Isolation Exam Room
 - One per PACT Module? One per Clinic?
 - Mental Health shares access to waiting and check-in with Primary Care
 - MH Offices should be sized to accommodate families
 - Team Rooms for MH providers/staff with offices equipped like Consult Rm?
- 1.6 Dr. Mike Koopmeiners emphasized there must be change in the process of how things are designed:
- Plans should not have room labels and should merely be referred to as a "Patient Care Room 1" versus "Exam Room or Provider Office". This would make them Universal Rooms.
 - "Primary PACT and Secondary PACT" teams versus Provider/Nurse POD
 - Dr. Koopmeiners felt that equipment and furniture should be removed from the design process and be left to the local clinic leaders to determine how the spaces would be outfit. He felt that plans that, for example, show a labeled Dietician Office undermine the ability of the clinic leaders to make changes during the implementation of a project.
 - Dr. Koopmeiners wondered if this study would address whether services would be fee-based out or kept in the program. Would it address using non-traditional clinic hours?
 - He stressed clinic compartmentalization and the separation of waiting space and exam space. Key card or proximity badges to access to the patient care areas should be considered.
 - Ambulance entry for patient pick-up should be addressed and planned.
 - Strong reliance on tele-health capability now and in the future. More is better.
 - Shared Medical Appointments (by use of Group Rooms) should be made available and encouraged.

2.0 Space Requirements/Considerations – Large Clinic - Two PACT Module

- 2.1 Tracy Bond led the discussion of how we understand the threshold of when a clinic becomes multi-specialty.
- A small clinic is the "bread and butter" Primary Care/Family Practice
 - A large clinic is a multi-specialty clinic whose size is driven by the number of specialty services offered
 - A medium clinic is a hybrid between the small and large clinic
- 2.2 The Rapid City PFD provided is the base document for these assumptions:
- 6 teamlets currently programmed for primary care and 2 teamlets for specialty care
- 2.3 Increasing bariatric population. How will this impact the design of the modules?

- 2.4 Dr. Christine Emler stated the average age of patients is 75 years and they typically come to the clinics with a scooter or cane accompanied by a spouse and adult children.
- 2.5 Consider multiple use and capability “universal” rooms versus additional program specific spaces

26 September 2013

3.0 VA CBOC Maplewood Tour – 0830 - 1030

Attendees: Pete Yakowicz, C.B Alexander, Mia Briggs, Dr. Christine Emler, Dr. Mike Koopmeiners, Clyde Markon, Lori Baier, Mary Swain, Jay Sztuk, Linda Chan, Tracy Bond, Gabryela Passeto, and Chris Phillips

- 3.1 Clyde Markon gave a brief introduction about the Maplewood Clinic prior to the walk-thru:
 - Single story clinic with approximately 10,000 NUSF
 - Opened in March 2013 and serves approximately 4,000 patients
 - Hours of operation 0730 -1630; layout allows clinic to be secured for evening shared appointments or group therapy session
 - Primary Care clinic with mental health, pharmacy, audiology, radiology, vtel and 15 specialties for tele-medicine.
 - Each provider has two exam rooms and shares an office with another provider
 - Mental health is dispersed throughout the clinic to refrain from the stigma of “mental health” corridor
 - The women’s exam rooms are located near the nurses’ station to provide greater visibility
 - All exam rooms are set up to accommodate bariatric patient population – treatment tables are in the sitting position
 - No issues with patients and staff sharing circulation. This particular clinic prefers provider visibility and they know where their patients are at all times.
 - Supplies are delivered from the Medical Center weekly. Courier picks up lab and linens.
- 3.2 Lori Baier and Mary Swain escorted the team throughout the clinic. See attached floor plans for walk-thru notes and observations.

4.0 Brief visit with VISN Director

- 4.1 Janet Murphy shared some insight about the project scope:
 - Frustrated with lack of creativity and planning of the CBOC design process
 - Lack of consideration of neighbors (departmental adjacencies)
 - Dissatisfied with flow and functionality of the Maplewood Clinic
 - Although it’s a new clinic, they are already hoping to expand. Projects do not fully satisfy the need due to funding and approval limits.
 - Appreciates standardization, but can’t be too rigid. Must allow for local flexibility where appropriate
 - She also brought up the need for consistency in exterior design for branding. Jay explained that it is beyond the scope of this project

5.0 Scope of Services

- 5.1 Participants created a spreadsheet to discuss what services they feel should be offered in a large CBOC:
 - POC testing + onsite MLT testing
 - radiology + services + mobile docking (tech pad)
 - prosthetics
 - rehab
 - basic MH + substance abuse and complex care
 - consultative services - dermatology, cardiology, pulmonary, hem/onc, neurology, EKG, stress test
 - dispensing pharmacy (machine vs. retail)

- dental (no SPS)
- audiology
- optometry/ophthalmology
- non-sedative surgical capabilities
- orthopedic
- general, vascular surgery – urology
- SCI?
- women's health
- short term care (not urgent care)
- infusion clinic
- wound care services (imbedded in PC)
- co-managed care?
- on-site security?
- preventive health / wellness
- staff wellness - gym/locker space
- vending / retail shop (randolph shepard act)
- biomed?
- pharmacy cache
- materials mgmt.
- geriatric

- 5.2 Discussion of the provided Rapid City PFD was aborted in favor of creating the list provided in 5.1. Chris Phillips provided a list of comments and observances from his analysis of the Rapid City PFD to Luke Epperson.
- 5.3 Discussion was limited to the types of services that could be considered for the Large CBOC rather than any specific staffing or space requirements for those services.

6.0 Next Steps

- 6.1 Bi-weekly calls to provide a project update began on 24 September 2013. All participants are encouraged to call-in when their schedules allow.
- 6.1 Continue to kick-off the meetings at the remaining VISNs:
- VISN 8 – 2-3 October (Tampa, FL)

END OF MINUTES

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Prototype for Standardized Design and Construction of Community Based Outpatient Clinics

VISN 23 - Minneapolis Kick-off Meeting

LOCATION: VISN 23 Headquarters

DATE: 09/25/2013

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PROJECT: 28319.000 VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date: 25 - 26 September 2013
 Location: Minneapolis, Minnesota

Day 1: 25 September 2013 – VISN 23 Headquarters

Recommended Attendees: VISN Representative, Key Stakeholders and Decision Makers, Medical Center Leadership and Clinic Leadership

- 1330 – 1345 Introduction
- 1345 – 1415 Team presentation outlining past experience including Patient Centered Medical Home
- 1415 - 1500 Project Scope
 - Design Goals
 - Expectations
 - Final Deliverable
- 1500 – 1515 Break
- 1515 - 1600 Prototype Development, Design Modules and Schematic Design for 3 clinic sizes

Day 2: 26 September 2013 – VISN 23 Headquarters

Recommended Attendees: VISN Representative, Key Stakeholders and Decision Makers, Medical Center Leadership and Clinic Leadership

- 0830 – 1030 Clinic Tours – location TBD (design team only)
- 1030 – 1100 Drive time
- 1100 – 1200 Program for Design + User Interviews
- 1200 - 1300 Lunch
- 1300 - 1400 Program for Design + User Interviews continued
- 1400 - 1415 Break
- 1415 - 1545 Concept of Operations Discussion
 - Pros + Cons of Existing Facilities
 - Functional and Operational Issues
 - Flow Diagrams
 - Optimal Departmental Adjacencies
- 1545 - 1600 Closing + Next Steps

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 20 October 2013
 Meeting Date 2-3 October 2013
 Location James A. Haley Veteran's Hospital
 Purpose Kick – off Meeting

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.sztuk@va.gov
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Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	chris.phillips@theinnovagroup.com

ITEM	DISCUSSION	ACTION
	2 October 2013	
1.0	Kick-off Meeting <i>Attendees: Kathleen Fogarty, David VanMeter, Gloria Hilton, Dr. Denietolis, Mike Rogala, William Messina, Jose Busquets, Dr. Stenzler, Edward Cutolo, Rita Mercier, Cheri Jensen, Donald Davis, Dr. Ochipa, Tyler harris, Jessica Ferraro, Colleen Park, Jay Sztuk, Tracy Bond, Gabryela Passeto, and Chris Phillips</i>	
1.1	Jay Sztuk explained that this project stems from observations made while estimating leased CBOCs. Each project design started “from scratch” and VACO has not been able to successfully standardize. He also gave a brief timeline of the project and emphasized the purpose is not to think in terms of “my clinic/their clinic” but “our clinics”, with all participants contributing to the design decisions for each location. <ul style="list-style-type: none"> The road to this project started as a submission to the VA Innovation Program. The first 	

phase was a feasibility study aimed at identifying the best approach for standardization. Due to the wide range of facility sizes within VA it was determined that development of a modular kit of parts would have the best chance of success.

- Now the goal is to develop the prototypes. SmithGroupJJR was selected and has recently completed a similar project for the Navy.
- The best chance for success of a CBOC prototype that implements PACT is local buy-in to the concepts. Three VISNs are involved and will represent three projects at different sizes. This will show the prototype translated through larger sizes.

- 1.2 Tracy Bond welcomed the attendees and explained the purpose of this kick-off meeting is to engage the leadership, to organize the team and to begin the work. She briefly introduced the team's working experience on Navy Medicine Patient Centered Medical Home (PCMH) studies and other naval projects from macro to micro level. The goal is to make collaborative discussion and emphasized that this is a holistic team project and the team includes everyone in the room.
- 1.3 Jay stated that for the purposes of this study, new construction is the direction, but will have to be adaptable for leased spaces with modifications.
- 1.4 Kathleen Fogarty stated women's health is the most increasing service in the VA CBOCs.
- Women want a separate entrance to their clinic. They do not want to walk thru a waiting room full of men.
- 1.5 Chris Phillips summarized the highlights of the two other VISN Kick-off Meetings:
- Current Maui CBOC has 3 teamlets
 - Small CBOC Prototype should include at least one PACT Module (4 teamlets)
 - Specialty services are provided by visiting specialty providers
 - Will space be provided to include VBA?
 - This is important for CBOCs that are very remote
 - Tele-Health/Tele-Medicine must be addressed
 - Discussion ensued on including fiber to every room to accommodate any future bandwidth requirements
 - Isolation Exam Room
 - One per PACT Module? One per Clinic?
 - Mental Health shares access to waiting and check-in with Primary Care
 - MH Offices should be sized to accommodate families
 - Team Rooms for MH providers/staff with offices equipped like Consult Rm?
- 1.6 Kathleen Fogarty asked if growth is accounted for in this study. Most times, a clinic is already undersized once occupants move in because the design and funding process takes so long.
- Chris Phillips explained that accommodations for growth should occur during the planning stage rather than design.
 - Kathleen Fogarty is also concerned that new clinic designs do not support PACT

2.0 Space Requirements/Considerations – Medium Clinic - Two PACT Module

- 2.1 Tracy Bond led the discussion of how we understand the threshold of when a clinic becomes multi-specialty.
- A small clinic is primary care only
 - A medium clinic is primary care with ancillaries and minor procedure. Dr. Denietolis stated 70% of the CBOCs fall under this category
 - A large clinic is all of the above with the possibility of procedural modules such as colonoscopy, vasectomies, etc. and are unique by region
 - Depth of other services drives clinic size; primary care is not the main driver of clinic size
- 2.2 The Brooksville PFD provided is the base document for these assumptions:
- 6 teamlets currently programmed for primary care and 2 teamlets for specialty care
- 2.3 Provide 1 minor procedure room with bariatric exam table and patient lift. Procedures are very infrequent in primary care.
- 2.4 Consider multiple use and capability "universal" rooms versus additional program specific spaces
- 2.5 Integrate virtual care space throughout the clinic

3 October 2013**3.0 VA Primacy Care Annex (PCA) Tour – 0800 - 1000**

Attendees: Kathleen Fogarty, Dr. Denietolis, Mike Rogala, William Messina, Rita Mercier, Colleen Park, James Dahnke, Jay Sztuk, Tracy Bond, Gabryela Passeto, and Chris Phillips

3.1 The participants decided to tour the PCA as part of this study instead of Brooksville. The PCA is currently under construction and was designed using PACT guidelines.

3.2 Dr. Denietolis gave a brief introduction about the PCA prior to the walk-thru:

- Two story clinic with approximately 110,000 SF
 - Primary Care clinic with mental health, pharmacy, audiology, physical therapy, radiology, laboratory, phlebotomy, pain clinic and dental
- 24 teamlets
- Mental health has rooms integrated in primary care and has its own service
- The women's clinic is located on the lower level with a dedicated entrance (5 teamlets)
- Clinic will be operational in spring 2014.

3.3 Dr. Denietolis escorted the team throughout the clinic. Drawings were not available to the team for walk-thru notes, but drawings were provided after the visit.

Scope of Services**4.0 Mental Health – Dr. Ronald Gironda – 1130 -1200**

4.1 Dr. Gironda understands the desire to integrate mental health services in primary care, but believes it should be a hybrid model instead depending on the size of the clinics.

- In severe cases, sensitized individuals need quiet dedicated spaces. Slamming of doors and high traffic areas can be problematic for those individuals

4.2 Strong preference for individual offices. Hoteling space is not conducive to their model of care.

4.3 Provide ample group rooms to encourage shared appointments

4.4 Provide a safe room for patients that need to calm down or become aggravated

- Tracy Bond suggested this could be part of the security room component for the clinic, rather than having a completely empty room for these seldom occurring scenarios.

4.5 During the discussion of furniture layout/placement, Dr. Gironda stated the typical return table separating the therapist and patient is not conducive to the patient/therapist relationship.

4.6 A room with study carrels for paper testing would be appropriate.

5.0 Audiology – Dr. Cynthia Ochipa – 1330-1415

5.1 The need and capacity depends on how far a CBOC is located with respect to the Medical Center.

5.2 For true Compensation and Pension (C&P) testing., the provider and patient are both in separate double walled booths

5.3 Basic vestibular service provided – a step up from just hearing aids, but not fully specialized

5.4 Tele-Health for Speech Pathology.

5.5 Brooksville will have three audiobooth suites.

5.6 Full audio suite recessed in concrete

- Optimally located on the first floor
- Embedded in the clinic, not along the perimeter

6.0 Specialty Care – 1415 -1530

6.2 Optometry – Tele-retinal room provided.

6.3 Prosthetics – Physical Therapy Tech and Prosthetics Tech can be interchangeable.

6.4 Dermatology – Universal minor procedure room?

6.5 Laboratory

- Point of Care Testing (POCT) should be typical in a Medium CBOC.
 - Provide 4 drawing stations
 - Pregnancy and Coumadin Testing
- 6.6 Home Based Primary Care (HBPC)
- Could be included in any CBOC. Staffing number is specific to that area.
- 6.7 Pharmacy – Currently provide, not dispense. ADDs room with service window and consult room for clinical pharmacist required. No dispensing medications out of the Automated Dispensing Device (ADDs) machine.
- 6.8 Women's Health –
- Women are given the choice to go through Primary Care versus a separate women's clinic during the eligibility process
- 6.9 Dental – Not included in Brooksville
- 6.10 Physical Therapy – One PT and exercise area.
- 6.11 Tele-medicine/Tele-health – Should be readily available throughout the clinic.

7.0 Next Steps

- 7.1 Bi-weekly calls to provide a project update began on 24 September 2013. All participants are encouraged to call-in when their schedules allow.
- 7.2 Synthesize information from the VISN 21, 23 and 8 to prepare for the Space Programming Charrette in Washington DC on 17 October 2013.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.



Prototype for Standardized Design and Construction of Community Based Outpatient Clinics

VISN 8 - Tampa Kick-off Meeting

LOCATION: James A. Haley Veterans' Hospital

DATE: 10/01/2013

Print) First / Last NAME	1-Oct	Organization	Your Position / Title	Phone / Internet	E-mail
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PROJECT: 28319.000 VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date: 2 - 3 October 2013
 Location: Tampa, Florida

Day 1: 2 October 2013 – James A. Haley Veterans’ Hospital

Recommended Attendees: VISN Representative, Key Stakeholders and Decision Makers, Medical Center Leadership and Clinic Leadership

- 1330 – 1345 Introduction
- 1345 – 1415 Team presentation outlining past experience including Patient Centered Medical Home
- 1415 - 1500 Project Scope
 - Design Goals
 - Expectations
 - Final Deliverable
- 1500 – 1515 Break
- 1515 - 1600 Prototype Development, Design Modules and Schematic Design for 3 clinic sizes

Day 2: 3 October 2013 – James A. Haley Veterans’ Hospital

Recommended Attendees: VISN Representative, Key Stakeholders and Decision Makers, Medical Center Leadership and Clinic Leadership

- 0700 – 8:00 Arrive at VAMC and Drive Time (design team only)
- 0800 – 0930 Brooksville Clinic Tour (design team only)
- 0930 – 1100 Tour wrap-up and drive time
- 1100 – 1200 Program for Design + User Interviews
- 1200 - 1300 Lunch
- 1300 - 1400 Program for Design + User Interviews continued
- 1400 - 1415 Break
- 1415 - 1545 Concept of Operations Discussion
 - Pros + Cons of Existing Facilities
 - Functional and Operational Issues
 - Flow Diagrams
 - Optimal Departmental Adjacencies
- 1545 - 1600 Closing + Next Steps

PROJECT: 28319 **VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities**

Date 10 October 2013
 Meeting Date 8 October 2013
 Location Conference Call
 Purpose Bi-weekly Project Update

PARTICIPANT	COMPANY	PHONE	EMAIL
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ITEM	DISCUSSION	ACTION
1.0	Project Update – 1400 <i>Attendees: Jay Sztuk, Dr. Denietolis, Dr. Newcomb, Peter Yakowicz, Tracy Bond, Gabryela Passeto, Emily Dickinson, Mike Cook, Chris Phillips, Kelly Soh and Bill Hoffman</i>	
1.1	Tracy Bond informed participants of where the project stands since the last project update on 9/24/13: <ul style="list-style-type: none"> The team kicked off the project with the leadership and key stakeholders at VISN 21, VISN 23 and VISN 8 No specific additional agenda items to discuss at this time Meeting minutes from all 3 site visits are being produced 	
1.2	Chris Phillips informed participants the progress that was being made on the Programs for Design: <ul style="list-style-type: none"> Review of the Maui and Rapid City PFDs were underway The team is still waiting on the PFD for Tampa Developed a 1 PACT Module PFD for discussion 	
1.3	Tracy Bond turned the focus on the upcoming DC Programming Charrette: <ul style="list-style-type: none"> The purpose of the charrette is to define the program requirements for the small, medium and large prototype Scheduled for 17 October 2013 at SmithGroupJJR office from 0930 – 1630 Key decision makers and stakeholders are encouraged to attend Due to funding constraints, a WebEx will be provided for participants calling in 	
1.4	SmithGroupJJR will research alternative presentation methods to accommodate participants to be involved when travel is limited.	

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

smallest was about \$5,000 BGSF

The clinical services departments, in particular, can be accommodated in highly standardized spaces. Anecdotally, by standardizing bay sizes and utilizing offsite-constructed components, including partitions and mechanical trays, the speed of project delivery and the ability to quickly change layouts represents a significant opportunity. This can be accomplished while avoiding overly rigid solutions.

Table 1. Frequency of Occurrence of Departmental Spaces in 26 CBOC Precedent Projects

	DEPARTMENT	Frequency	Area (SF)	% of Occurrence	S	M	L
284	Acquisition and Material Management	11	27,389	42%	✓	✓	✓
262	Ambulatory Care & OP Clinics	26	636,427	100%		ALL	
284	AMM Administration	2	3,733	8%	-	-	-
204	Audiology and Speech Pathology Clinic	16	52,479	61%	-	✓	✓
	Building Common Areas	4	56,318	15%			
	Building Equipment Areas	3	32,079	11%			
206	Canteen <i>vending (s) cafe</i>	21	38,236	80%	-	✓	✓
210	Cardiovascular Labs	9	9,702	35%			
	Central Reception Area	1	2,498	4%			
410	Centralized Staff Lockers, Lounges and Toilets	1	878	4%			
220	Credit Union	1	195	4%			
287	Cystoscopy Suite and Support	5	14,798	19%			
222	Dental Clinic	19	67,938	73%	-	?	✓
	Dermatology	1	3,073	4%			
316	Dialysis	1	10,493	4%			
238	Director's Suite / Clinic Management Suite	17	25,913	65%			
	Ear, Nose, & Throat Clinic	1	1,142	4%			
402	Education Facilities	22	42,520	85%			
226	EEG – Neurology	5	3,838	19%			
287	Endoscopy Suite (Digestive Diseases)	3	7,256	11%			
230	Engineering	20	9,059	77%			
406	Environmental Management <i>(BIOMED)</i>	22	34,226	85%	✓	✓	✓
233	Eye Clinic	19	39,199	73%	-	✓	✓
	Facility & Medical Support	1	2,695	4%			
234	Fiscal Service	1	2,252	4%			
	Hospital-Based Home Care (HBHC) <i>HOMEBASES PRIMARY CARE</i>	1	3,076	8%	-	✓	✓
266	Human Resources (Personnel)	1	2,616	4%			
239	Information Resource Management Service (ADP)	4	5,124	15%			
244	Lobby	26	105,170	100%			
410	Lockers, Toilets and Showers <i>staff</i>	20	24,437	77%			
	Management Staff	3	9,553	12%			
246	Medical Administration Service	21	34,719	81%			
	Medical Records	1	2,153	4%			

Final Draft

VBA / HBHC /

can be shared - holding space + commit rooms for more

278	Medical Research and Development	1	1,047	4%	
	Medical Sub Specialty, Other	1	7,525	4%	
260	Mental Health Clinic	24	145,504	92%	✓ ✓ ✓
	Miscellaneous	3	5,717	12%	
275	MRI	2	7,115	8%	
254	Nursing Service Administration	1	902	4%	
224	Nutrition/Food – Dietetics	1	338	4%	
	Oncology and Chemotherapy	1	2,992	4%	
	Orthopedic Clinic	1	1,070	4%	
240	Pathology and Laboratory Medicine (PLM)	26	64,266	100%	✓ ✓ ✓
268	Pharmacy Service	21	76,887	81%	- ✓ ✓
270	Physical Medicine and Rehabilitation	10	38,394	38%	- - ✓ ✓
	Podiatry	1	1,181	4%	
279	Police and Security Service	24	10,629	92%	- ✓ ✓
	Primary Care	1	7,916	4%	
308	Prosthetics and Sensory Aids	15	17,803	58%	- ✓ ✓
212	Pulmonary Medicine – ?	10	6,627	38%	- - ✓ ✓
276	Radiology Service	26	98,082	100%	- ✓ ✓
270	Rehab Medicine	12	26,549	46%	- - -
280	Service Organizations <i>shared</i>	15	8,849	58%	
282	Social Work Service	1	320	4%	
	Specialty Care	1	7,062	4%	
202	Substance Abuse Clinic	1	1,655	4%	
284	Supply Administration	8	18,366	31%	
285	Supply Processing and Distribution (SPD) ?	15	33,361	58%	- - ✓
286	Surgery ?	11	109,558	42%	- - ✓
	Telecommunication (IT) Equipment Areas	5	3,636	19%	
	Urology	1	1,126	4%	
218	Veterans Assistance Unit	3	6,233	12%	
	VBA <i>TBD</i>	1	1,887	4%	
290	Voluntary Service	23	9,615	88%	
	Waiting Areas	1	4,637	4%	
291	Warehouse	8	15,156	31%	
	Women's Health <i>shared</i>	2	24,902	8%	- ✓ ✓

S M L

*plac
draw @
small clinic*

*Wait to
present at
all full
VBA*

*NO
SURGERY,
MINOR
PROCEDURE*

- Now the goal is to develop the prototypes. SmithGroupJJR was selected and has recently completed a similar project for the Navy.
- The best chance for success of a CBOC prototype that implements PACT is local buy-in to the concepts. Three VISNs are involved and will represent three projects at different sizes. This will show the prototype translated through larger sizes.

2.0 Meeting Purpose + Goal

2.1 Tracy summarized the purpose and goal of the Space Programming Charrette:

- Update attendees on the progress of the project
- Discussion of the CBOC Prototypes (Small, Medium and Large)
- Confirm the scope of services included in CBOC Prototypes
- Validate Programs for Designs developed for each CBOC Prototype
- Review expectations for the Preliminary Submittal
- Discuss the agenda for follow-on design charrettes

3.0 Preliminary CBOC Prototype Overview

3.1 Tracy summarized the 3 different clinic sizes used in this study:

- The small clinic prototype is 11,157 DGSF/13,157 BGSF
- The medium clinic prototype is 32,885 DGSF/41,107 BGSF
- The large clinic prototype is 55,702/69,627 BGSF

3.2 Jay suggested providing additional clarification on the slide to indicate this is a basis of design for each clinic and to list what the unique specialties that are included. Each VISN will begin with the prototype and add/remove services based on their specific demands.

3.3 As the team looked at a more prototypical or baseline program for design for the three different sizes, we found that the primary care was not the main driver, but instead the ancillary and specialty services drove the growth.

3.4 Jay confirmed for the purposes of this study, the term 'teamlet' and 'team' are interchangeable.

4.0 Preliminary CBOC Prototype: Planning Assumptions

4.1 Primary Care PACT Assumptions are as follows:

- Small = 4 teams (4,800 uniques)
- Medium = 8 teams (9,600 uniques)
- Large = 12 teams (14,400 uniques)

Specialty Care Assumptions are as follows:

- Small CBOC provides primary care and mental health only (no other specialty care)
- Medium CBOC provides specialty care to a geographic region that includes its own primary care base, plus two additional Small CBOCs (or equivalents), with 4,800 uniques each, for a supported specialty care population of approximately 19,200
- Large CBOC provides specialty care to its unique primary care population, plus three additional CBOCs in the region, for a supported specialty care population of 28,800
- Specialties included in the draft PFDs were determined during the previous week's meeting, but will be refined based upon charrette discussions.

Scope of Services

5.0 Acquisition and Material Management Service

5.1 Tracy question whether including this service was dependent a clinic proximity to a parent VA

- Kelly added it is driven by geographical location

6.0 Patient Aligned Care Team (PACT) Module

6.1 Kelly explained these assumptions were taken straight from the July 2013 draft criteria

- There are some discrepancies with the grossing factor across the board
 - Current criteria uses 1.65

- PACT criteria use 1.5
- Assumption used for the Prototype PFDs is 1.52

6.2 Currently, the PACT modules do not take into account efficiencies between the small, medium and large, but these will be worked on during the upcoming charrettes

7.0 Audiology and Speech Pathology

7.1 Dr. Newcomb stated that due to the changes in providing Compensation and Pension (C&P), detailed booth testing is no longer required. He added the demand has dropped about 50%

7.2 In Tampa, Dr. Denietolis stated a booth was added to have capability of C&P if needed. She added that if there is a question and an exam is needed, a booth is required.

7.3 Dr. Denietolis and Dr. Newcomb both agreed that if there isn't enough workload to support 2 audiologists, then a clinic should not offer the service.

8.0 Canteen

8.1 The first bullet on slide 14 should read, Less than 50,000 projected total annual outpatient visits. The second bullet should read, Less than 50,000 total FTE clinic positions

8.2 Bob Bearden suggested all CBOCs should have a vending area at a minimum especially since the model of care is focusing more on the patient experience.

8.3 Important to consider the Randolph Sheppard Act

9.0 Home-Based Primary Care (HBPC)

9.1 Pete believes the decision to provide this service in any of the CBOCs should be geography driven

9.2 Dr. Newcomb stated HBPC should be integrated within the team work areas, or float/open offices for the providers in the clinic. As this service transitions to the virtual care modality, the providers will need access to Tele-health rooms

- Tracy questioned why there would be a need to provide private offices for staff that are not present during most clinic hours
- A touchdown/hoteling space will be provided in the clinic.

9.3 Jay suggested we have a discussion with the HBPC team to determine what their needs are prior to the first design charrette.

10.0 Dental

10.1 Currently, only providing dental services in the large CBOC

10.2 Stand-alone dental clinic requires duplicating services

10.3 SPD requirements have kept dental services out of the clinics in the past

11.0 Engineering

11.1

- No issues identified

12.0 Eye Clinic

12.1 Linda questioned including optometry in the medium and optometry and ophthalmology in the large.

- Linda asked if PACT concepts should be borrowed when building the program for Eye Clinic

12.2 Dr. Newcomb stated the current criteria locks the providers into a different model of care

- Currently, providers do not room the patient and this is a big picture issue that won't be resolved within this study

13.0 Mental Health

- 13.1 Dr. Newcomb asked if the homeless population is typically associated with social work or mental health
- Dr. Denietolis answered that not all homeless veterans have mental health issues. They are part of social work, embedded in PACT. It would be an insult to the patient to embed them in mental health. She added that some of the homeless veterans simply had bad luck
- 13.2 The programed mental health space is in addition to the BHIP within the PACT module
- 13.3 In some cases, depending of the population, the mental health footprint may be larger than primary care within the same clinic

14.0 Pathology and Laboratory Medicine

- 14.1 Dr. Koopmieners stated a dedicated specimen toilet is needed in all clinics, not just the medium and large.
- Chris explained the criteria does not support a dedicated specimen toilet, however within the PACT module, there are numerous patient toilets that can be shared to support the laboratory

15.0 Pharmacy

- 15.1 Chris stated the pharmacy component included in these clinics is based on the automation a particular clinic will have and the flow that is used.
- 15.2 A vault for narcotics is provided in the large clinic
- 15.3 The Omnicell or Pyxis machine will be controlled by a pharmacist located off-site in the small clinic

16.0 Physical Medicine and Rehabilitation (PM+R)

- No issues identified

17.0 Police and Security

- No issues identified

18.0 Prosthetics and Sensory Aids

- No issues identified

19.0 Pulmonary Medicine

- The group determined that the exercise room could also be used for cardiology stress testing
- The team will develop a multi-specialty clinic module for inclusion in the large CBOC, which should be flexible in terms of the specialties which share the space

20.0 Radiology

- 20.1 Dr. Koopmieners stated that with the growing number of women veterans, it should be standard to include mammography, ultrasound and bone density capabilities in all clinics where radiology is included
- 20.2 Omit dedicated chest room. Linda says this is from criteria and is very dated.

21.0 Other considerations for inclusion in the PFD

- 21.1 Multi-disciplinary specialty clinic module
- 21.2 Clinical management is not a service and should be embedded in every clinic

21.0 Next Steps

- 21.1 Adjust Prototype Programs for Design based on the feedback from the steering committee.
- 21.2 The Preliminary Submittal will be submitted on 1 November 2013.
- 21.3 Prepare for the 2-day design charrette hosted in VISN 23 Headquarters in Minneapolis.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

- 1.5 Tracy requested a copy of the current PACT Draft Criteria that is being done by others from Gary. A Final draft will be available in early December.
- 1.6 Jay will be setting up conference calls with Canteen Service and Home Based Primary Care to discuss their program requirements prior to the charrette.
- 1.7 Next Steps:
 - Preliminary Submittal: 1 November 2013
 - Charrette #1 Minneapolis: 13-14 November 2013

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 30 October 2013
 Meeting Date 30 October 2013
 Location Teleconference
 Purpose Defining Space Program – Canteen Service

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.sztuk@va.gov
Sylvia Wallace	Chief Engineer, VA Canteen Services	314-845-1252	Sylvia.wallace@va.gov
Tracy Bond	SmithGroupJJR, Project Manager/Architect/Medical Planner	202-974-5161	tracy.bond@smithgroupjjr.com
Gabryela Passeto	SmithGroupJJR, Architect/Medical Planner	202-974-0830	gabryela.passeto@smithgroupjjr.com
Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com
Kelly Soh	The Innova Group, Healthcare Planner	703-842-4339	Kelly.soh@theinnovagroup.com

ITEM DISCUSSION ACTION

- 1.0 Space Programming: Canteen Service – 1130 - 1230**
Attendees: Jay Sztuk, Sylvia Wallace, Tracy Bond, Gabryela Passeto, Chris Phillips and Kelly Soh
- 1.1 The purpose of the discussion is to clarify the approximate size and scope of canteen services located in typical small, medium, and large CBOCs
- 1.2 Sylvia clarified that vending operations belong to VA Canteen Services, while staff break rooms do not.
- 1.3 The VA Space Planning Criteria are useful for estimating services provided:
 - < 50K SF CBOCs typically support approximately 600 visits per day, earning a Starbucks and a deli.
 - CBOCs with 400 visits per day are authorized a Starbucks only. The VA is not an official Starbucks’ franchise, but Canteen Services brews Starbucks coffee.
 - CBOCs with more than 1,200 visits per day are authorized more than a Starbucks and deli.
 - Very few CBOCs are large enough to support full food courts. They are typically > 200 SF.
- 1.4 Canteen Services operate under Non Appropriated Funds (NAF), and thus must be self-sustaining, in terms of covering costs with sales revenue.
- 1.5 There is no standard template for Canteen Services facility options, but Sylvia has access to mocked-up layouts. The layouts are being revised, and she will send them to the group within a week.
- 1.6 With the layouts from Sylvia’s group, Chris should be able to modify the programmed space for the CBOC prototypes. Currently, the programs for design (PFDs) include placeholders for Canteen Services at 400 NSF in both the Medium and Large prototypes. The small CBOC prototype currently includes vending only.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 19 November 2013
 Meeting Date 5 November 2013
 Location Conference Call
 Purpose Bi-weekly Project Update

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	Director of Cost Estimates, CFM	202-632-5614	Jay.sztuk@va.gov
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Ward Newcomb	PCS, 10P4F, PACT Space	334-221-5353	William.newcomb@va.gov
Larry Janes	VISN 21 Capital Asset Manager	707-562-8213	Larry.janes@va.gov
Tracy Bond	SmithGroupJJR, Project Manager/Architect/ Medical Planner	202-974-5161	tracy.bond@smithgroupjjr.com
Gabryela Passeto	SmithGroupJJR, Architect/Medical Planner	202-974-0830	gabryela.passeto@smithgroupjjr.com
Kelly Soh	The Innova Group, Healthcare Planner	703.842.4339	Kelly.soh@theinnovagroup.com
Bill Hoffman	URS, Mechanical Engineer	202-772-0612	Bill.g.hoffman@urs.com

ITEM DISCUSSION ACTION

1.0 Project Update – 1400

Attendees: Jay Sztuk, Linda Chan, Pete Yakowicz, Dr. Ward Newcomb, Larry Janes, Tracy Bond, Gabryela Passeto, Kelly Soh, and Bill Hoffman

- 1.1 Gabryela started the meeting informing participants the Preliminary Submittal was published on 1 November 2013 and asked if anyone had any trouble opening the link sent for file exchanges
- Jay added something needed to be done with file management as the size of the submittal was too large to send via email
 - He sent reviewers Sections 1-7 for participants to review as Section 10; the appendix was too large of a file.
 - Gabryela stated she will work on reducing the files sizes without compromising the quality of the graphics for the next submittals.
 - Jay asked reviewers to submit comments by COB on Friday 11/8 in order for the consultants to address them during the DC Charrette
 - Jay would like to use DrChecks to facilitate handling review comments for this effort. Not all reviewers have accounts set up and this will need to be done for the next submittal. For this go around, all comments will be sent to Jay for distribution to SGJJR.
- 1.2 Tracy turned the focus to the upcoming charrette in DC:
- Jay explained the deviation in the schedule is due to funding issues on the VA side and has kept most of the decision makers in this process from traveling for the charrette. He is confident these issues will be resolved for the January Charrette in Tampa, but in the meantime, SmithGroupJJR will be hosting the meeting with the core steering group and providing the layouts and presentation to participants calling in via webex so they can follow along. The charrette scheduled for Minneapolis will be tacked on as an additional visit as Charrette #4 (see attached schedule)
 - The charrette is scheduled for Wednesday 11/13 and Thursday 11/14 from 1200 - 1600 EST to accommodate all times zones.

- Tracy explained the purpose of the charrette is to review the layouts of the small CBOC prototype in terms of circulation, flow, and room functions on Day 1. Day 2 will be more focused on how the layout changes in the medium and large CBOC prototypes as other services are integrated and departmental adjacencies are studied with respect to PACT principles. In addition, review comments will be discussed and additional programming questions will be addressed.

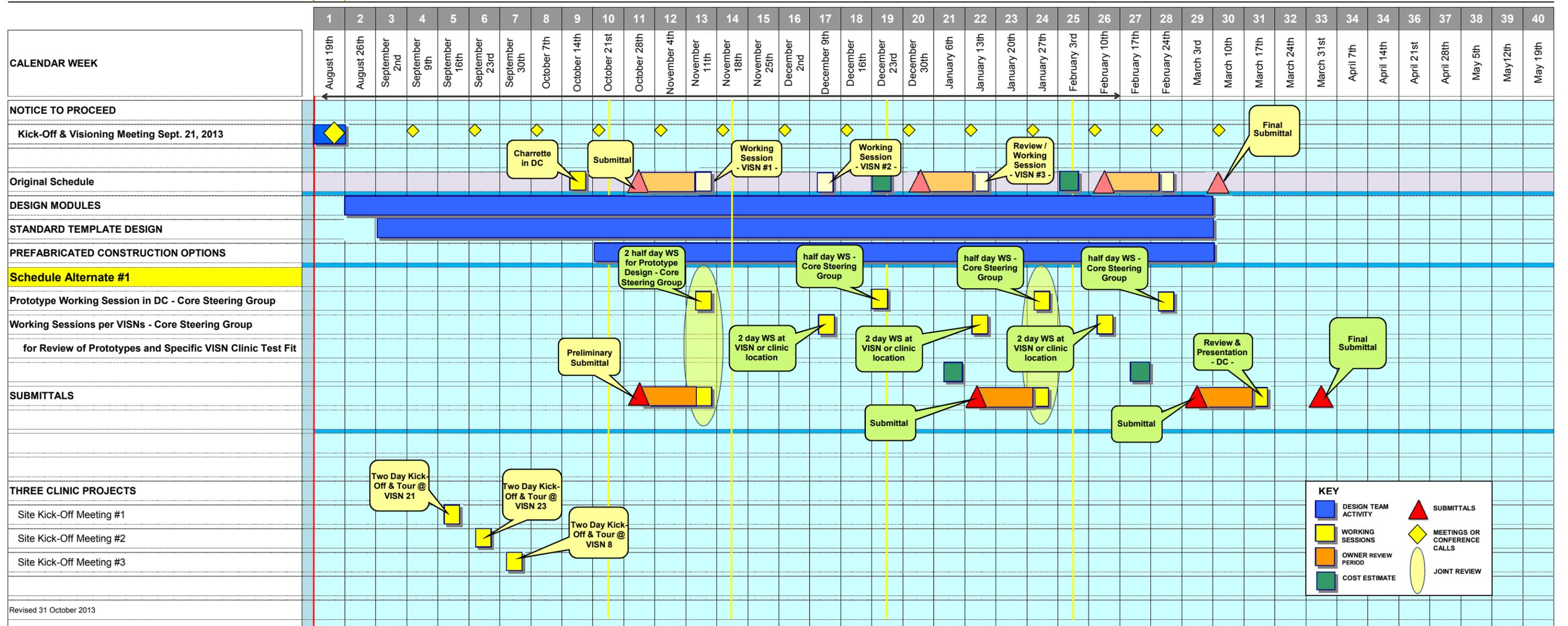
1.4 Next Steps:

- Charrette DC 13-14 November 2013

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjir.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

Project Execution Schedule - Alternate Schedule



PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 22 November 2013
 Meeting Date 13 - 14 Novmeber 2013
 Location SmithGroupJJR Conference Room
 Purpose Charette DC + Preliminary Review Meeting

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.sztuk@va.gov
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Ashley Andersen	SmithGroupJJR, Architect	202-974-4516	Ashley.andersen@smithgroupjjr.com

The following participated via tele-conference

Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	chris.phillips@theinnovagroup.com
Ved Gupta	Xxxxxx	xxx-xxx-xxxx	xxxxxxx@va.gov
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John Kaine	xxxxxx	xxx-xxx-xxxx	xxxxxxx@va.gov
Don Myers	Xxxxxx	xxx-xxx-xxxx	xxxxxxx@va.gov
Craig Oswald	VAPIHCS, Exec. Assistant to the Director/Facility Strategic Planner	808-433-0100	Craig.oswald@va.gov

ITEM DISCUSSION ACTION
13 November 2013

1.0 Charrette_DC – Day 1

Attendees: Jay Sztuk, Gary Fischer, Linda Chan, Alejandra De La Torre, Lloyd Siegal, Ding Madlansacay, Dr. Newcomb, Dr. Denietolis, Rick Murphy, Ved, Gupta, Peter Yakowicz, Larry Janes, Timothy Bertuccio, Sylvia Wallace, Luke Epperson, Orest Doolittle, Mike Rogala, Susan Bestgen, John

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Kaine, Don Myers, Craig Oswald, Tracy Bond, Gabryela Passeto, Chris Phillips, Ashley Andersen and Negar Ghassemieh

- 1.1 Jay Sztuk began with a brief introduction reemphasizing that this project stems from observations made while estimating leased CBOCs. Each project design started “from scratch” and VACO has not been able to successfully standardize. He also gave a brief timeline of the project and emphasized the purpose is not to think in terms of “my clinic/their clinic” but “our clinics”, with all participants contributing to the design decisions for each location.

- The road to this project started as a submission to the VA Innovation Program. The first phase was a feasibility study aimed at identifying the best approach for standardization. Due to the wide range of facility sizes within VA it was determined that development of a modular kit of parts would have the best chance of success.
- Now the goal is to develop the prototypes. SmithGroupJJR was selected and has recently completed a similar project for the Navy.
- The best chance for success of a CBOC prototype that implements PACT is local buy-in to the concepts. Three VISNs are involved and will represent three projects at different sizes. This will show the prototype translated through larger sizes.

2.0 Meeting Purpose + Goal

- 2.1 Tracy summarized the purpose and goal of the Charrette_DC:

- Update attendees on the progress of the project
- Confirm the scope of services included in CBOC Prototypes
- Validate Programs for Designs developed for each CBOC Prototype
- Review the Preliminary Submittal Content and answer review comments
- Discuss the agenda for follow-on design charrettes
- Get consensus on basic prototype layout

3.0 Project Schedule

- 3.1 Tracy reviewed the change in schedule:

- Jay explained the deviation in the schedule is due to funding issues on the VA side and has kept most of the decision makers in this process from traveling for the charrette. He is confident these issues will be resolved for the subsequent charrettes in Mare Island and Tampa.

- 3.2 The Progress Submittal falls on the same week as the charrette in Tampa

- The group decided it would be best to submit after the findings in Tampa for a more complete submittal

- 3.3 The charrette scheduled for Minneapolis will be tacked on as an additional visit as Charrette #4 (refer to page 5 on the attached presentation)

4.0 Preliminary Submittal Overview and Review Comments

- 4.1 Tracy outlined the contents of the preliminary submittal issued on 1 November 2013. Sections 6, 8 and 9 were left as placeholders in the submittal for reviewers to understand the intent. Those sections will be further developed in subsequent submittals as well as incorporating findings of upcoming charrettes.

- 4.2 The design team reviewed each of the preliminary submittals comments and provided responses followed by a group discussion for decision making:

- All exam rooms and consult rooms should be programmed at 125SF. The draft PACT space planning criteria shows Exam at 125 sf already but Consult Rooms are shown as 120 sf.
- Waiting/Reception Areas
 - Dr. Denietolis stated they must remain for family members and sensitive appointments. They have gotten smaller since the patients should be roomed upon arrival, but eliminating them completely is not a good model.
 - Orest added patient kiosks need to be accommodated in the waiting areas with privacy panels

- Need dedicated tele-health and tele-retinol rooms. These rooms can be flexed.
 - VBA
 - Lloyd states this component should be part of the building rather than a separate entity
 - Pete agrees it should be considered at all CBOC sizes
 - Craig added that VBA is a transformation initiative and it is critical to have at every CBOC regardless of size
 - Dental
 - Susan Bestgan states that dental should be included in every clinic if the workload supports it. Unless a clinic can support 2 dentists or 6 chairs at a minimum, it is not appropriate to include dental. It was discussed that although the small prototype did not include Dental, any specific project could use the Dental module shown in the medium or large, if required.
 - Orest added criteria is changing dental treatment rooms to 130 SF
 - Canteen Service
 - Sylvia reminded the group that the canteen presence is based on the visits and FTE to determine whether it will be a blind vendor service or a retail store component
 - Conference rooms should have dual function
 - Police and Security – should a larger footprint be considered for the Large CBOC?
 - Chris stated there is a ops room for cameras. A large clinic may have more security officers, but space isn't necessarily increased since officers should be roaming the clinics
- 4.3 Gabryela stated the responses to the comments will be included in the meeting minutes as well as subsequent submittals.

5.0 CBOC Prototype Overview

- 5.1 Tracy summarized the 3 different clinic sizes used in this study:
- The small clinic prototype is 11,537 DGSF / 14,421 BGSF
 - The medium clinic prototype is 35,370 DGSF / 44,213 BGSF
 - The large clinic prototype is 61,338 / 76,673 BGSF
- 5.2 Jay suggested providing additional clarification on the slide to indicate this is a basis of design for each clinic and to list what the unique specialties that are included. Each VISN will begin with the prototype and add/remove services based on their specific demands.
- 5.3 As the team looked at a more prototypical or baseline program for design for the three different sizes, we found that the primary care was not the main driver, but instead the ancillary and specialty services drove the growth.
- 5.4 Dr. Denietolis stated the term 'teamlet' and 'team' are not interchangeable. 4 people is a universal model and the smallest unit is a 'teamlet'

6.0 CBOC Prototype: Planning Assumptions

- 6.1 Primary Care PACT Assumptions are as follows:

- Small = 4 teams (4,800 uniques)
- Medium = 8 teams (9,600 uniques)
- Large = 12 teams (14,400 uniques)

Specialty Care Assumptions are as follows:

- Small CBOC provides primary care and mental health only (no other specialty care)
- Medium CBOC provides specialty care to a geographic region that includes its own primary care base, plus two additional Small CBOCs (or equivalents), with 4,800 uniques each, for a supported specialty care population of approximately 19,200
- Large CBOC provides specialty care to its unique primary care population, plus three additional CBOCs in the region, for a supported specialty care population of 28,800
- Specialties included in the PFDs were determined during previous meetings, but will be

refined based upon charrette discussions.

7.0 Defining Characteristics – One to Three PACT Modules

- 7.1 Dr. Denietolis stated that doubling consult rooms as modules grow is not necessary since staffing doesn't change.
- Tracy added that consolidation of spaces were not addressed in the PACT module thus far, but is intended to be a point of discussion during this charrette to create desired efficiencies.
 - Each room should have tele-health capabilities
 - Each room should have a grey box for plumbing to convert easily to exam rooms as required
 - Lloyd stated that if you are trying to make a more comfortable environment, the sink makes it clinical and deters from the concept of patient centered
- 6.2 The team will include in the narratives a description of what defines a module.

8.0 Other Considerations for Inclusion in the PFD

- 8.1 Wellness Center – a space for staff members within the clinic. In some cases can be shared with patients during non-clinic hours. There was no clear decision on whether this would be added to any of the prototypes. This could be part of the unique requirements for a specific CBOC project.
- 8.2 Patient resource center / library – could be part of patient education
- Would require shelving space for materials as well as 4 computer carousals
- 8.3 Volunteer Services – currently not included and does not need to be located within the PACT module
- This space typically supports 1 volunteer as well as wheel chair storage and a hospitality coffee cart.
 - Volunteer typically meets patient at the exam room with their wheel chair
 - Craig added the DAV Van Transportation Program could share this type of space. DAV acts as a dispatcher that picks up and delivers veterans to and from CBOCs.
- 8.4 Homeless showers - . There was no clear decision on whether this would be added to any of the prototypes. This could be part of the unique requirements for a specific CBOC project.

9.0 Review of Options 1 and 2 – Small CBOC Prototype

- 9.1 Tracy described the flow and layout of the proposed option.
- The reception area is centrally located upon entering the clinic with waiting areas flanking both sides. To the left is a dedicated group room and storage area for mental health, while a large shared medical appointment room backfills the remaining front bay of the clinic. The intent of placing those large shared spaces in the front of the clinic is to allow the clinic to be secured when hosting after hour programs to patients.
 - The patient exam rooms and staff teaming spaces are located at the center of the clinic with ample, comfortable circulation for staff and patients.
 - Staff support functions are located at the rear of the clinic and building support spaces, such as logistics are located in an adjacent column bay.
 - Consult rooms are dispersed throughout the clinic
 - A mental health module is located off the patient corridor to one side of the clinic
 - In option 2, the laboratory is located directly behind the reception
- 9.2 General feedback was to change the naming convention of 'mental health' to 'consult/exam' room
- 9.3 Pete disagreed with the location of the mental health rooms and stated they should be integrated with primary care and not located off a separate corridor.
- Linda added that this is typically driven by the level of acuity of the patient
 - Angie suggested to specify a level of sound masking for these types of rooms to avoid the need for a white noise machine
 - She added it doesn't really matter where those rooms are located since they never get the sound requirements during construction

- Lloyd suggested hanging white noise machines above the ceiling for all rooms
- 9.4 Patient flow:
 - Lloyd stated it is imperative to remember that the care is supposed to go to the patient, not vice versa
 - A patient shouldn't have to go to weights and measure and a separate blood draw room
 - Dr. Denietolis added it is unrealistic to place a scale in every room. It takes up space and is costly and is usually cut during the construction process.
- 9.5 Laboratory – Gary and Lloyd both stated that phlebotomy rooms and blood draw rooms are a thing of the past. They believe that true patient centered brings the nurses to the exam room.
 - Dr. Denietolis and Dr. Newcomb argued that there are patients seen at the clinic that visit strictly for routine blood draw samples. Those patients do not need to be roomed and can go directly to a blood draw room. It also frees up an exam room in the clinic.
 - Pete added the busiest hours for blood draw are between 8-10am since most patients are fasting.
 - Two blood draw chairs are preferred for the small prototype. The number in the medium and large appear to be fine, but can be addressed during follow-on charrettes.
 - Patients on chronic opiates come in monthly for urine testing
 - Two specimen toilets are preferred. One with no sink for said testing and the other with a specimen pass-thru
- 9.6 Soiled and Clean Utility – currently include a clean utility at approximately 60 NSF
 - Dr. Denietolis asked if there is a need for a soiled utility room.
 - Currently, they use a hamper that is located in the procedure room
 - Orest added the current Outpatient Clinic criteria (dated 2006) requires a clean utility of 100 NSF and a soiled utility of 80 NSF. However, Dr. Newcomb agreed that the draft PACT space planning criteria did not include a Soiled Utility. The group agreed that the hampers provided in exam and procedure rooms would be sufficient.
- 9.7 Following a break, SmithGroupJJR made edits to the layout based on the feedback from the participants. The naming convention of the mental health rooms was changed. The mental health rooms were dispersed within primary care and the team also showed the interchangeability of staff teaming area modules of how they could be additional exam room if they needed to grow.

10.0 Wrap Up + Close

- 10.1 SmithGroupJJR will present options for the Medium CBOC Prototype for review and discussion with participants in the first half of Day 2 as well as begin addressing departmental adjacencies once in the large CBOCs with diagrams.
- 10.2 The charrette will resume at 12 noon EST on 14 November 2013.

14 November 2013

Charrette_DC – Day 2

Attendees: Jay Sztuk, Gary Fischer, Linda Chan, Alejandra De La Torre, Lloyd Siegal, Ding Madlansacay, Dr. Newcomb, Dr. Denietolis, Rick Murphy, Ved, Gupta, Peter Yakowicz, Larry Janes, Timothy Bertuccio, Sylvia Wallace, Luke Epperson, Orest Doolittle, Mike Rogala, Susan Bestgan, John Kaine, Don Myers, Craig Oswald, Tracy Bond, Gabryela Passeto, Chris Phillips, Ashley Andersen and Negar Ghassemieh

11.0 Key Highlights from Day 1

- 11.1 Consult rooms will be programmed 125 SF, vice 120 SF per current criteria
- 11.2 Every universal room will have data and plumbing capabilities
- 11.3 Hamper included in the procedure and exam rooms, replaces the need for Soiled Utility
- 11.4 Regulated Medical Waste (RGM) is addressed and stored in Biohazard storage located in the

- Acquisition and Materials Management area
- 11.5 Volunteer Alcove – approximately 120 SF + wheelchair storage 60 SF
- Dr. Denietolis added they don't anticipate storing more than 8 wheelchairs at any given time.
 - Tim Bertuccio added the clinic wheelchairs are also stackable, which helps with space conservation
- 11.6 Laboratory – follow paradigm for the Medium CBOC
- Deep blood draw room for patients coming solely for routine tests
 - Phlebotomist goes to patient room when blood draw is required during encounter
 - Specimen toilet added with sink outside in the lab room
 - Patient toilet with specimen pass-thru
- 11.7 2 additional equipment alcoves located in staff teaming area. Med prep alcove with under counter refrigerator for immunizations
- 11.8 Patient kiosks will be included in the waiting area with a privacy screen
- 11.9 Tele-Retinal will be added as the 2nd Tele-Health room
- 11.10 Dental Operatories will increase from 120 SF to 125 SF
- 11.11 Mental Health office will be name changed to Consult room
- 11.12 VBA – one shared office included
- Dr. Koopmeiners is strongly against having a VBA presence in the clinics. He believes it needs to be vetted throughout the agency first
 - Rick Murphy stated this is beyond a policy issue and won't be resolved in this study
- 12.0 Tracy reviewed the revisions made to the Small CBOC in Option 1 from the previous day:**
- The conference room was pulled towards the front of the clinic
 - A VBA office was provided
 - Exam/consult rooms are dispersed
- 12.1 Dr. Koopmeiners accused the design team of being against PACT principles.
- Tracy responded that the design team is 100% for the principles of medical home and the VA PACT model of care. The team has extensive experience with this model of care for DoD and private sector implementation worldwide.
- 12.2 The participants agreed that an office would be appropriate to add in the clinic, but does not need to be within the waiting areas.
- The design team will describe the intent of this space in the narratives
 - Visiting leadership touchdown space
 - Part-time admin space
- 12.3 Women's Health – currently showing two with an adjoining toilet for each
- Dr. Denietolis stated that with less than 5,000 women veteran population, there is no real need for the rooms at all. Perhaps 1 dedicated women's health room is sufficed?
 - If showing 2 dedicated women's health rooms, they should be adjacent to one another, not located across the corridor as it would only be 1 women's health provider.
 - The second women's health room could be done in the now multi-function procedure room as required.
 - Gary said this is a workload specific matter and both options should be shown
- 12.4 Jay suggested considering a variety of column bays for the staff teaming areas.
- Currently the layout uses a 6'-0" staff corridor
 - The steering group believes this can be achieved in a smaller corridor
- 12.5 Lloyd asked to refrain from showing 'potential growth' on any of the plans. Conceptually it makes sense, but it should not be published in the design guide.
- 12.6 Health Administration Service (HAS) does all the appointing for the patients
- HAS demands a private office and they typically get it and should be programmed
 - Supervises clerks that are seated in the reception
 - Work room (copiers, fax, etc.) should be located near reception and collocated with HAS office
 - Clerks make follow-up appointments for patients in the exam rooms. Clerks could double as

schedulers/referrals at the front desk upon the patient exiting the clinic

13.0 VHA/VBA Discussion

- 13.1 Rick Murphy describes the mission of VBA is to have face to face contact with the veteran. VBA makes provisions for companions to join veterans during clinical appointments.
- 13.2 Presence in the CBOCs vary, in a small CBOC, there may only be a 0.5 FTE. Typical space requirements would be an office for private, counseling appointments and secure since PII information is stored.
- 13.3 In a larger CBOC, typical staffing would be 2 FTEs with 2 private office and a storage space
- 13.4 A job/career center where a veteran could do testing, write a resume, or receive support during job searches would be ideal.
- 13.5 Most veterans stop in during their clinic appointments and others are not always scheduled. Walk-ins are accommodated.

14.0 Review of Options 1 and 2 – Medium CBOC Prototype

- 13.1 Tracy explained how efficiencies were addressed in the Medium Prototype. Option 1, mirrors a One-PACT module, while Option 2 begins to consider spaces that can be shared. For some spaces, doubling the size of the clinic doesn't necessarily mean you double all of the spaces. The following are a list of proposed shared spaces in a Two-PACT module:

- Reception
- Staff Lounge
- Shared Medical Appointments
- Mental Health Group Rooms
- Potential to reduce dedicated Women's Health rooms from 4 to 2, while also having the ability the use of the procedure room as required.

- 14.2 Other considerations:

- 1 work room can be shared throughout the clinic
- In a clinic of this size, provide private offices for the RN Manager, Clinic Manager and visiting leadership

- 14.3 Mental Health

- The design team's understanding prior to this charrette is that mental health would be integrated in PACT in the small CBOCs. In the Medium and Large CBOCs they would be separate modules from PACT and have their own module. It was understood that when in a medium or large clinic, the module would be located adjacent to primary care for higher acuity patients and providers to give a 'warm' handoff.
- BHIP is still integrated in PACT and use consult rooms for this service.
- The participants could not come to a consensus on the matter. Jay will set up a conference call with the Integrated Mental Health representatives as well as the specialty mental health service to understand their program requirements

15.0 Medium and Large CBOC Prototypes – Blocking Diagrams

- 15.1 Tracy reviewed the different blocking diagrams to get show how some of these clinics may be laid out based on the desired adjacencies with the specialty clinics.
- 15.2 Dr. Denietolis stated the obvious adjacencies to her would be Laboratory and Radiology and Physical Therapy with Prosthetics
- 15.3 The design team will begin developing the specialty modules for feedback at the next charrette

16.0 Project Next Steps

16.1 Charrette_Mare Island will be held at VISN 21 Headquarters 10-11 December 2013

16.2 Participants agreed it is best to submit the Progress Submittal following the Charrette_Tampa scheduled for 14-15 January 2014.

- The next submittal will focus on the Planning Modules and Clinical Diagrams, Proposed Prototype Layouts and begin test fitting the programs for design from Maui, Rapid City and Brooksville

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.



Prototype for Standardized Design and Construction of Community Based Outpatient Clinics

Charrette DC

LOCATION: SmithGroupJJR Office, Washington DC

DATE: 11/13/2013

Print) First / Last NAME	Please Initial	Organization	Your Position / Title	Phone / Internet	E-mail
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LLOYD STEWART	CFM				

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Prototype for Standardized Design and Construction of Community Based Outpatient Clinics(CBOC)

Design Charrette
13 -14 November 2013
Washington, DC

Meeting Purpose + Goal

- Project Update
- CBOC Prototypes (Small, Medium, Large)
 - Confirmation of services included in each CBOC Prototype
 - Validate Programs for Design for each CBOC Prototype
 - Review and Develop Blocking & Circulation Diagrams
 - Basic Prototype layout



Design Charrette Agenda: Washington, DC

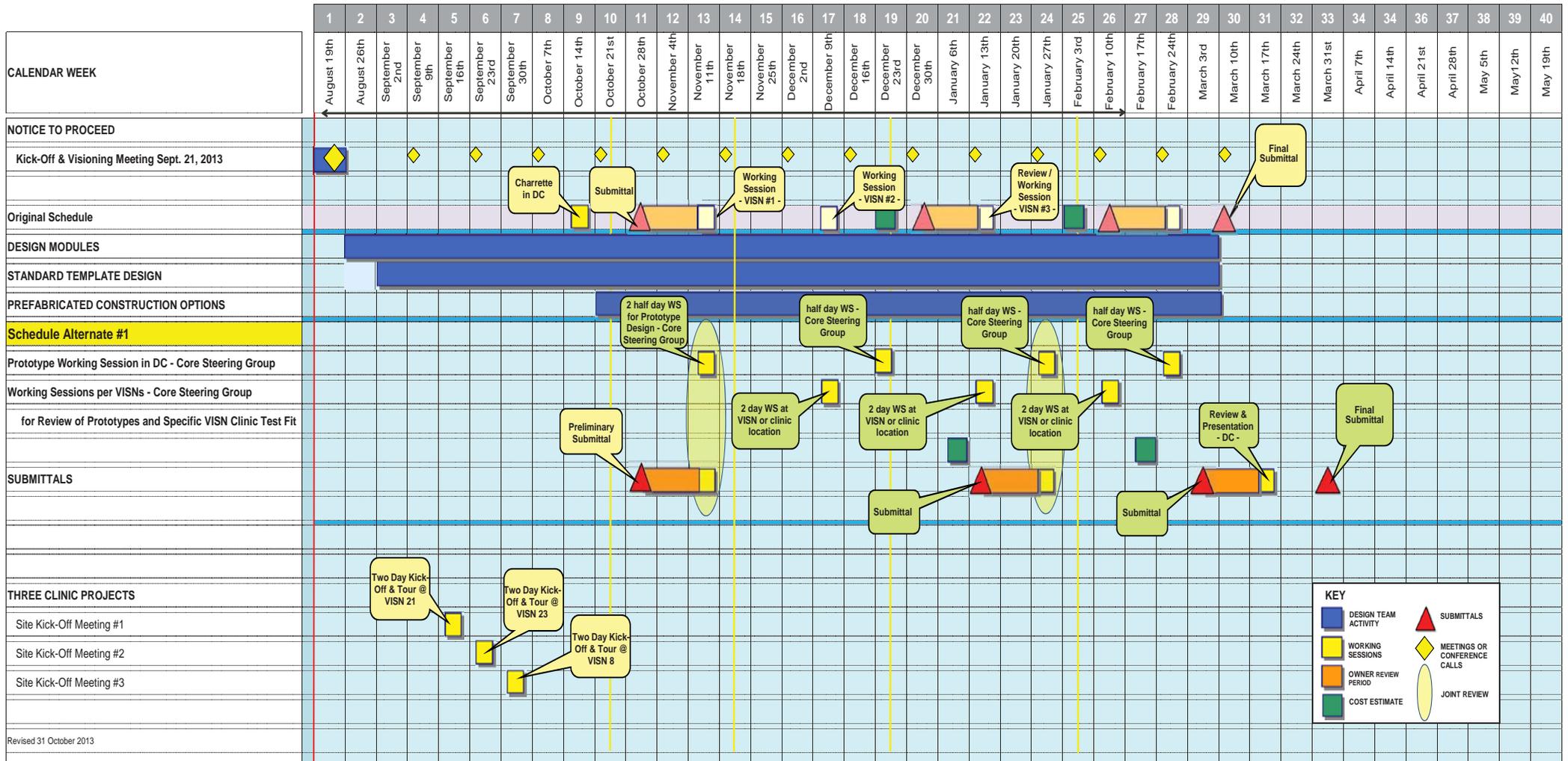
Day 1: 13 November 2013

- 1200 - 1230 Project Update
- 1230 - 1330 Preliminary Submittal Overview
- Review comments
- 1330 - 1530 Working Session Small CBOC
- Discuss optimal departmental flow and circulation
- Discuss desired adjacencies
- Review and refine proposed layout and modules
- Develop basic building blocks
- Refine program for design as necessary
- 1530 - 1600 Wrap-up
- Summarize options, address final comments and next steps

Day 2: 14 November 2013

- 1200 - 1230 Highlight Key Take Away from previous day
- 1230 - 1530 Working Session – Medium and Large CBOCs
Expanded from the Small CBOC discussion and outcomes, the purpose is to develop the Medium and Large CBOC Prototypes with the same considerations
- Confirm optimal departmental flow and circulation
- Confirm desired adjacencies
- Review and refine proposed layout and modules
- Refine program for design as necessary
- 1530 - 1600 Wrap-up
- Summarize options, address final comments and next steps

Project Execution



Project Schedule

Kick-off Meeting	21 August 2013
Hawaii Site Visit	16 - 20 September 2013
Minneapolis Site Visit	25 - 27 September 2013
Tampa Site Visit	1- 3 October 2013
Charrette in Washington DC [design modules and standard template design]	17 October 2013
Preliminary Submittal	1 November 2013
One Week Government Review and Comments	8 November 2013
Working Session #1 in Washington DC	13-14 November 2013
Working Session #2 in San Francisco / Mare Island	10-11 December 2013
Progress Submittal	TBD January 2014
Working Session #3 in Tampa	14-15 January 2014
Working Session #4 in Minneapolis	TBD 2014
Final Review and Presentation, Washington DC	TBD 2014



Preliminary Submittal Overview

Section 1 - Executive Summary

Section 2 - Project Narrative

Section 3 - CBOC Prototype Planning Assumptions

Section 4 - CBOC Prototypes Programs for Design

Section 5 - Planning Modules + Clinical Diagrams

Section 6 - CBOC Proposed Layouts

Section 7 - VA Test-fit Programs for Design

- VISN 21 - Maui, HI
- VISN 23 - Rapid City, MN
- VISN 8 - Brooksville, FL

Section 8 - Off-Site Construction Methods + Impact

Section 9 - Cost Estimates

Section 10 - Appendix

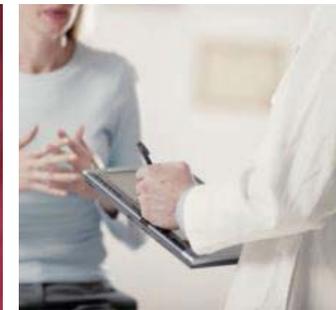
- Glossary of Terms
- Abbreviations
- References
- Appendix A (Local VISN Site Visits + Documentation)
- Meeting Minutes

Prototypes for Standardized Design and Construction Community- Based Outpatient Clinics



DESIGN GUIDE

PRELIMINARY SUBMITTAL
NOVEMBER 1, 2013



Preliminary Submittal Review Comments

Page	Comment	Response	Reviewer	Department
General	Why isn't the ratio of net to gross more closely aligned among the 3 sizes?		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Section 2	Project Narrative (2nd paragraph) includes functional and efficient; add flexible.		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Section 2	PACT Model Overview: Are the four rooms listed all one size and interchangeable? (Small CBOC shows 160 SF procedure, 125 SF exam, 120 SF consult) Best practice calls for universal rooms, at least for exam and consult rooms.		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
	Also, thought best practice calls for the elimination of wait/reception area, with scheduling done electronically in exam rooms.		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Section 2	Am I missing something? Figures 2.3 (One PACT), 2.4 (Two PACT), and 2.5 (Three PACT) are all the same. Why not show one illustration of Defining Characteristics?		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Section 3	large CBOC – typo 14,400 users not 14,200.		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Section 3	Scope of Services does not list space for telemedicine. Is that not included for each sized clinic?		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Section 7	Is the size of the large CBOC in Rapid City predicated on the possible closure of the Hot Springs campus?		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
General	Needs editing throughout.		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
General	Since VBA is restricted by Net Zero, there has been support for co-locating VBA services at CBOCs. Perhaps this should be considered for the larger prototype.		Nancy Zivitz Sussman	Office of Construction & Facilities Management (CFM)
Page 8	are the two and three pact module space diagrams correct. Seems like they should show different spaces...		Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
Page 9	Should there be a clinic Administrative service function/space need to each CBOC		Tim Bertuccio	VISN 21 Deputy Capital Asset Manager
Page 11	consider small Dental clinic for Med CBOC		Tim Bertuccio	VISN 21 Deputy Capital Asset Manager

Preliminary Submittal Review Comments – Cont.

Page	Comment	Response	Reviewer	Department
Page 11	consider small Dental clinic for Med CBOC		Tim Bertucco	VISN 21 Deputy Capital Asset Manager
Page 12	Does Engineering include facility maint or just Biomed?		Tim Bertucco	VISN 21 Deputy Capital Asset Manager
Page 12	consider Blind Vendor or Retail store for Large CBOC		Tim Bertucco	VISN 21 Deputy Capital Asset Manager
Page 26	Small CBOC should be under 10,000 NUSF for delegated leases		Tim Bertucco	VISN 21 Deputy Capital Asset Manager
Section 2	Figure 2.3, 2.4 and 2.5--Net SF Space Allocation by Functional Area is same SF in all three versions-One PACT Module, Two PACT Module and Three PACT Module.		Ved Gupta	Office of Construction & Facilities Management (CFM)
General	Is there any guideline for travel time to or distance between each Small CBOC/Medium CBOC/Large CBOC?		Ved Gupta	Office of Construction & Facilities Management (CFM)
Section 3	2 small CBOCs are planned to be attached to a Medium CBOC and only 3 small CBOCs are attached to a Large CBOC. Large CBOC seems to be very minimally differentiated from Medium CBOC in regards to Clinical and Admin services!! (just my observation). It seems that medium CBOC may be less desirable considering the difference in services.		Ved Gupta	Office of Construction & Facilities Management (CFM)
General	A prototype graphic example showing locations and inter-relationship of Small CBOC to Medium/Large may be helpful.		Ved Gupta	Office of Construction & Facilities Management (CFM)
Section 4	Conference room at each facility can also be programmed as a Group Education Room and as such could be a larger room (300-400 SF).		Ved Gupta	Office of Construction & Facilities Management (CFM)
Section 3	In item 3.2: a. Area for Prosthetics & Sensory Aids is missing b. Areas for Engineering and Police/Security for Large CBOC should be bigger than the area in Medium CBOC		Ved Gupta	Office of Construction & Facilities Management (CFM)
General	Some typo corrections required.		Ved Gupta	Office of Construction & Facilities Management (CFM)
General	No comments included for 3 planned CBOCs (I am not familiar with program requirements).		Ved Gupta	Office of Construction & Facilities Management (CFM)

PACT Module Overview

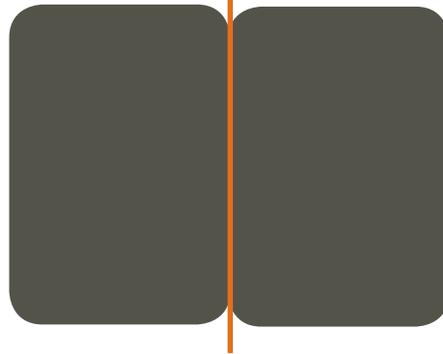
Small CBOC

- 1 PACT module



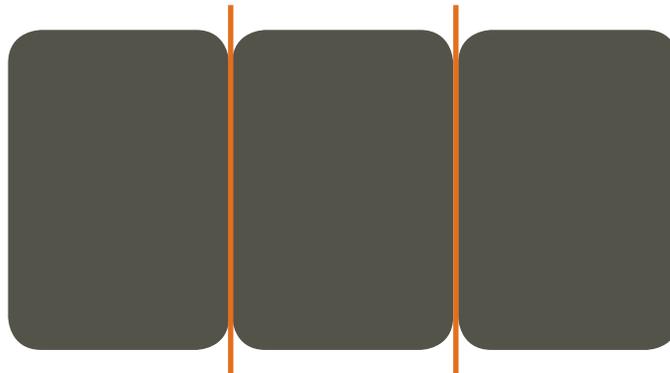
Medium CBOC

- 2 PACT modules

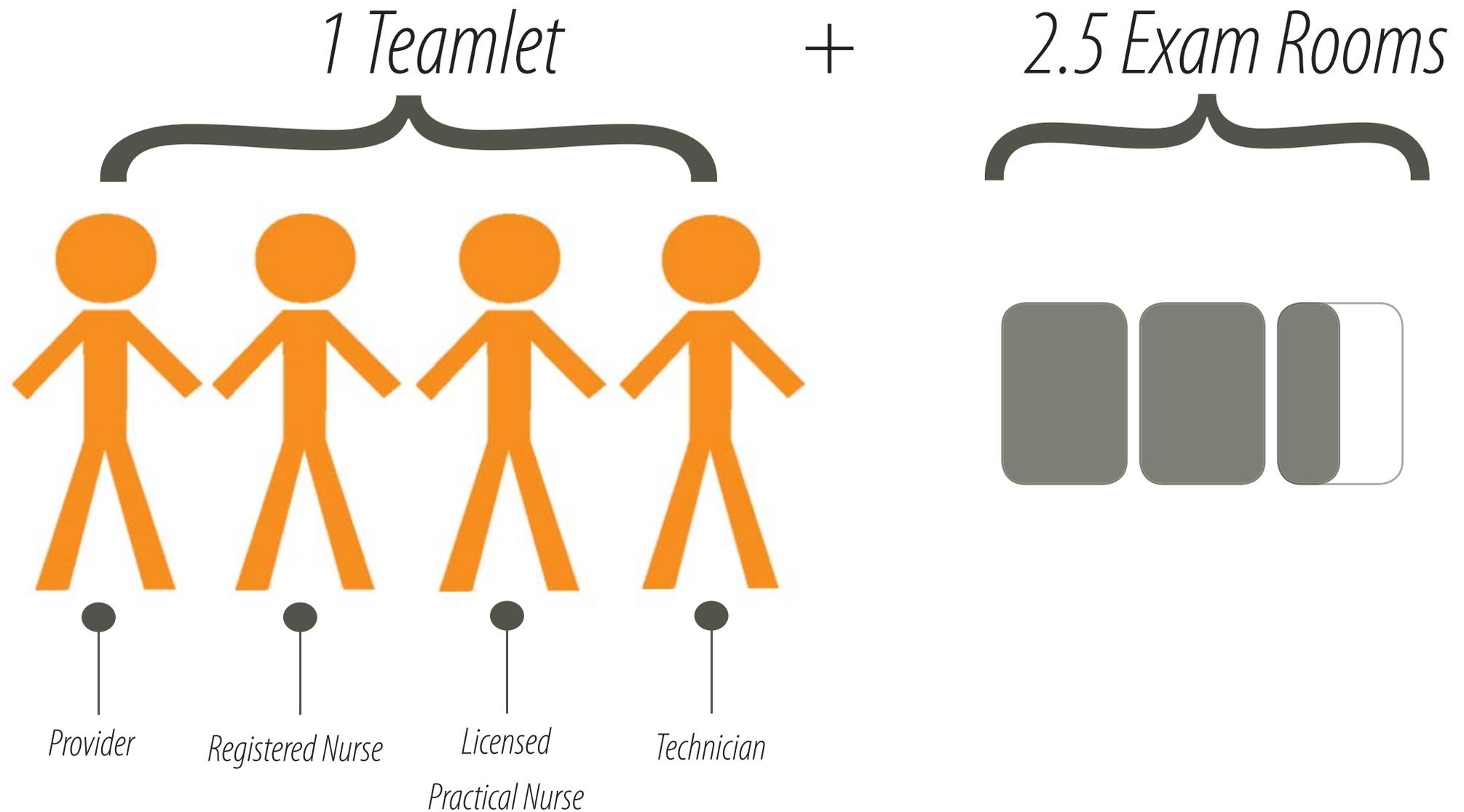


Large CBOC

- 3 PACT modules



Defining Characteristics: Teamlet



CBOC Prototype: Planning Assumptions

- Primary Care PACT
 - Small = 4,800 unique primary care users (4 teamlets)
 - Medium = 9,600 unique primary care users (8 teamlets)
 - Large = 14,400 unique primary care users (12 teamlets)
- Specialty, Ancillary and Administrative Services included per space programming meeting (10 October 2013)
- Medium and Large CBOCs provide specialty care for other smaller CBOCs
 - Medium = 19,200 unique specialty care users (+2 additional small CBOC equivalents)
 - Large = 28,800 unique specialty care users (+3 additional small CBOC equivalents)
- Number of specialty providers programmed in medium and large prototypes per *VISN 17 Planning & Facility Planning* population threshold recommendations
 - Credible, defensible rationale for scaling medium and large modules

CBOC Prototype Overview

Small

11,537 DGSF

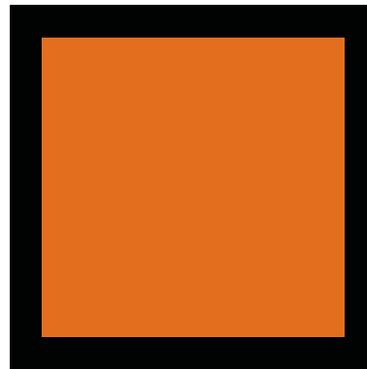
14,421 BGSF



Medium

35,370 DGSF

44,213 BGSF



Large

61,338 DGSF

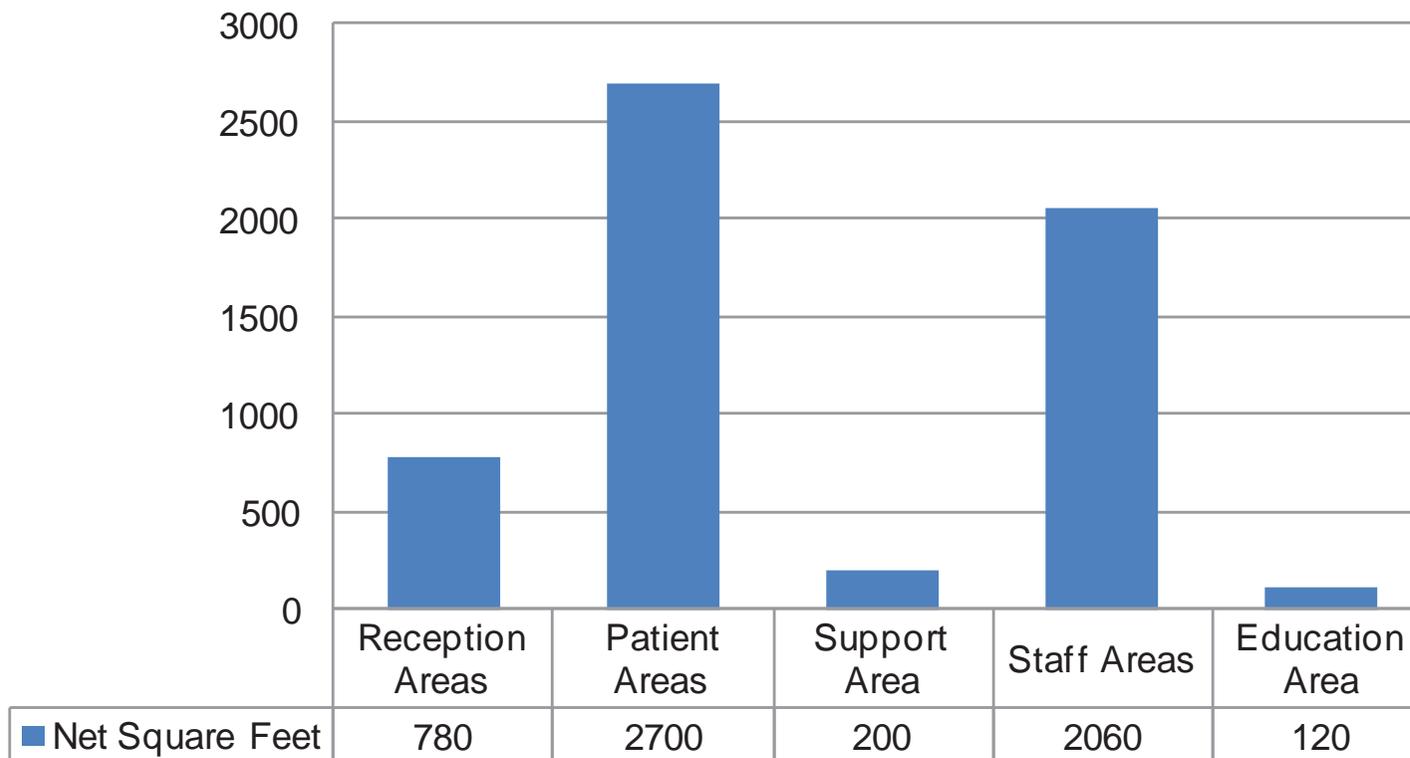
76,673 BGSF



Defining Characteristics: One PACT Module

Exam Rooms (PACT)	Exam Rooms (Women's Health)	Procedure Rooms	Consult Rooms
8	2	1	4

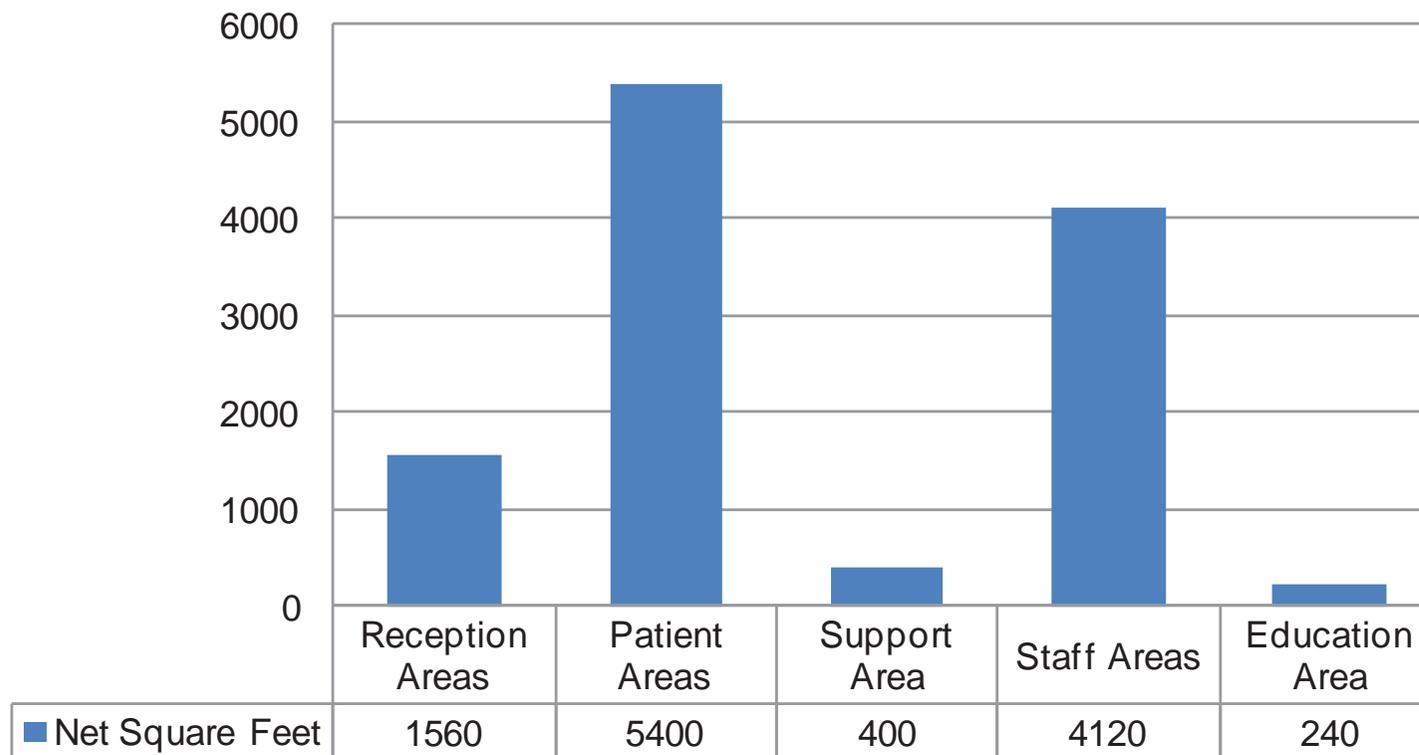
Space Allocation by Functional Area



Defining Characteristics: Two PACT Modules

Exam Rooms (PACT)	Exam Rooms (Women's Health)	Procedure Rooms	Consult Rooms
16	4	2	8

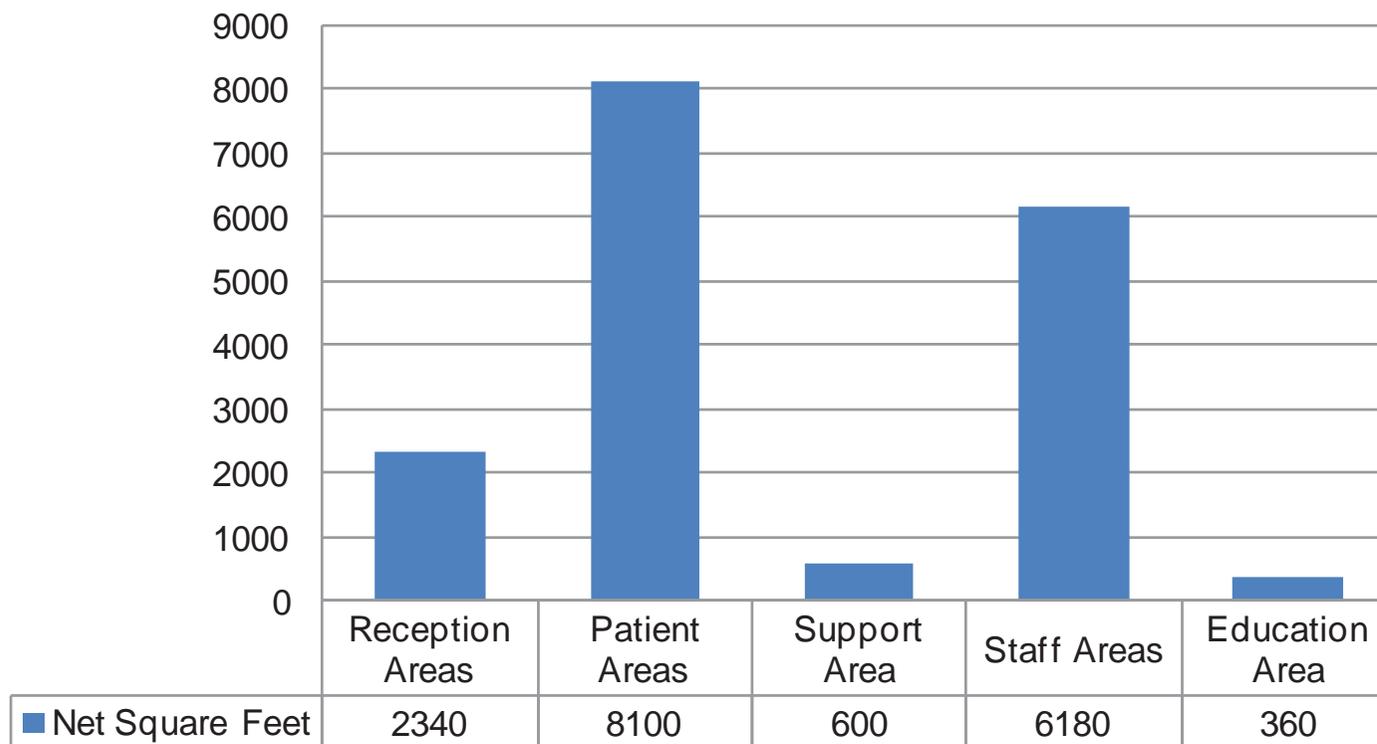
Space Allocation by Functional Area



Defining Characteristics: Three PACT Modules

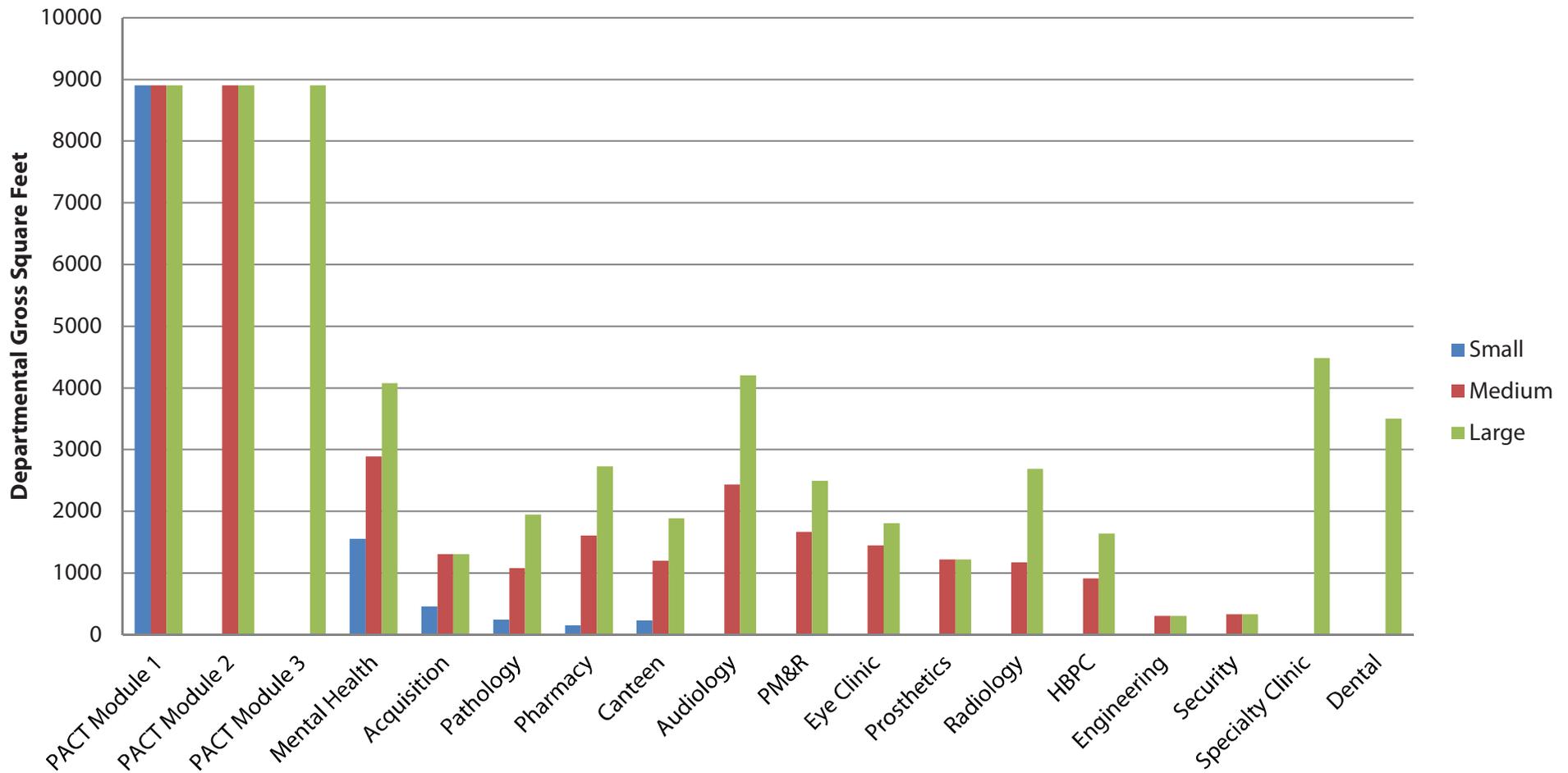
Exam Rooms (PACT)	Exam Rooms (Women's Health)	Procedure Rooms	Consult Rooms
24	6	3	12

Space Allocation by Functional Area



CBOC Prototype Space Comparison

Space Requirements by Department



Note: SEPS NSF-to-DGSF ratio of 1.52 applied to PACT Modules (new criteria suggests 1.50)

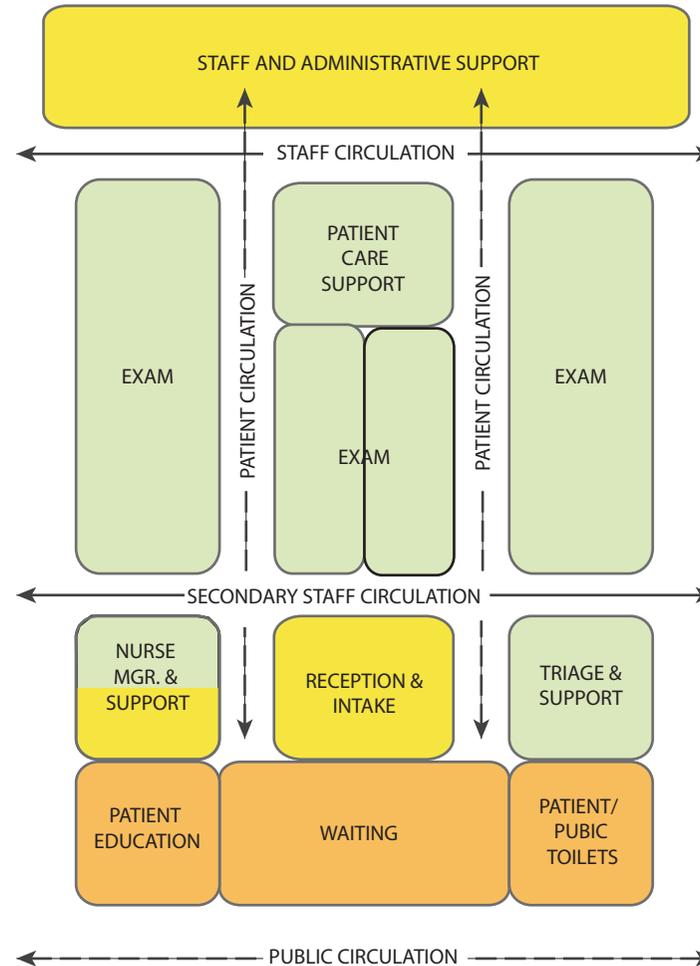
Other Considerations for Inclusion in PFD

- Clinical Management
- Environmental Management (Housekeeping Closets, etc...)
- Common Areas (lobby, staff lockers, staff lounges, staff toilets + showers)
- Building Support (Electrical closets, Mechanical Rooms, Communications Room)

VA Design Guide: CBOC Single Module

LEGEND - FUNCTION

- STAFF AND ADMINISTRATIVE AREAS
- OUTPATIENT SERVICES
- PATIENT / "PUBLIC" SPACES



Clinics Single Module Relationship Diagram

January 2009 Design Guide - Section 3-3

VA CBOC Single Module with Provider POD

LEGEND - FUNCTION

- STAFF AND ADMINISTRATIVE AREAS
- OUTPATIENT SERVICES
- PATIENT / "PUBLIC" SPACES

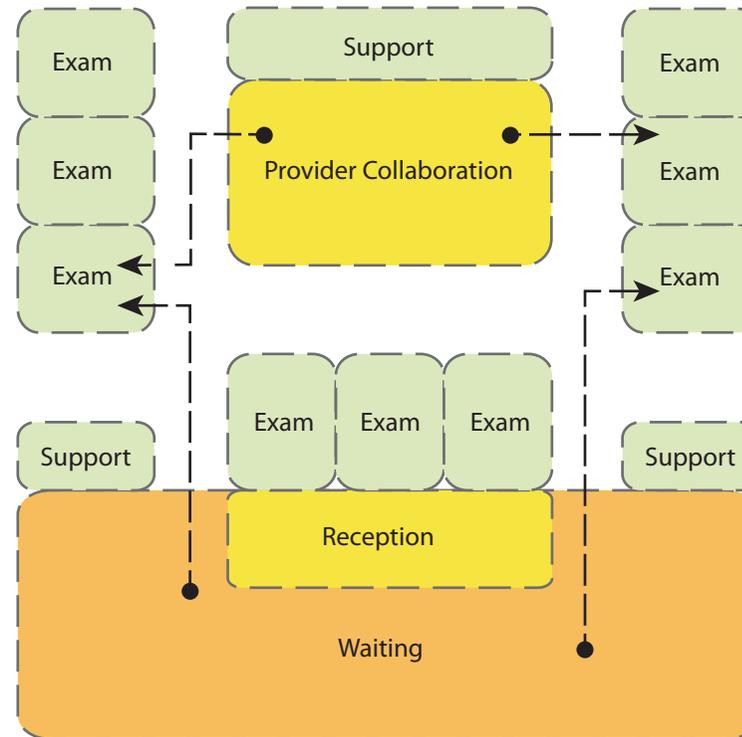


Figure 2. Standardized Space of a "Lean Pod" or "Clinical Model"

Feasibility Study for the Development of Standardized Designs for Outpatient Clinics - Final Draft July 22, 2013

Small CBOC Prototype : Block Diagram

LEGEND - CIRCULATION

← - - - PATIENTS

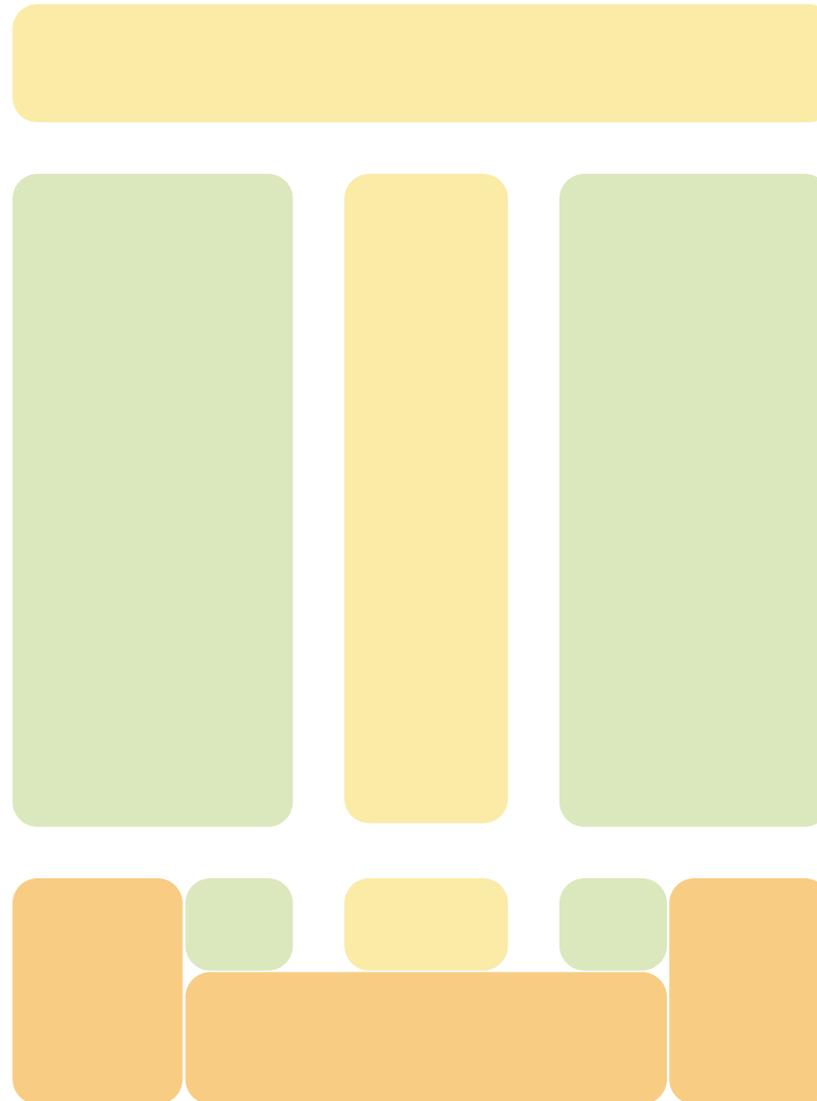
← - - - STAFF

← - - - SECONDARY

● PUBLIC

● PATIENTS

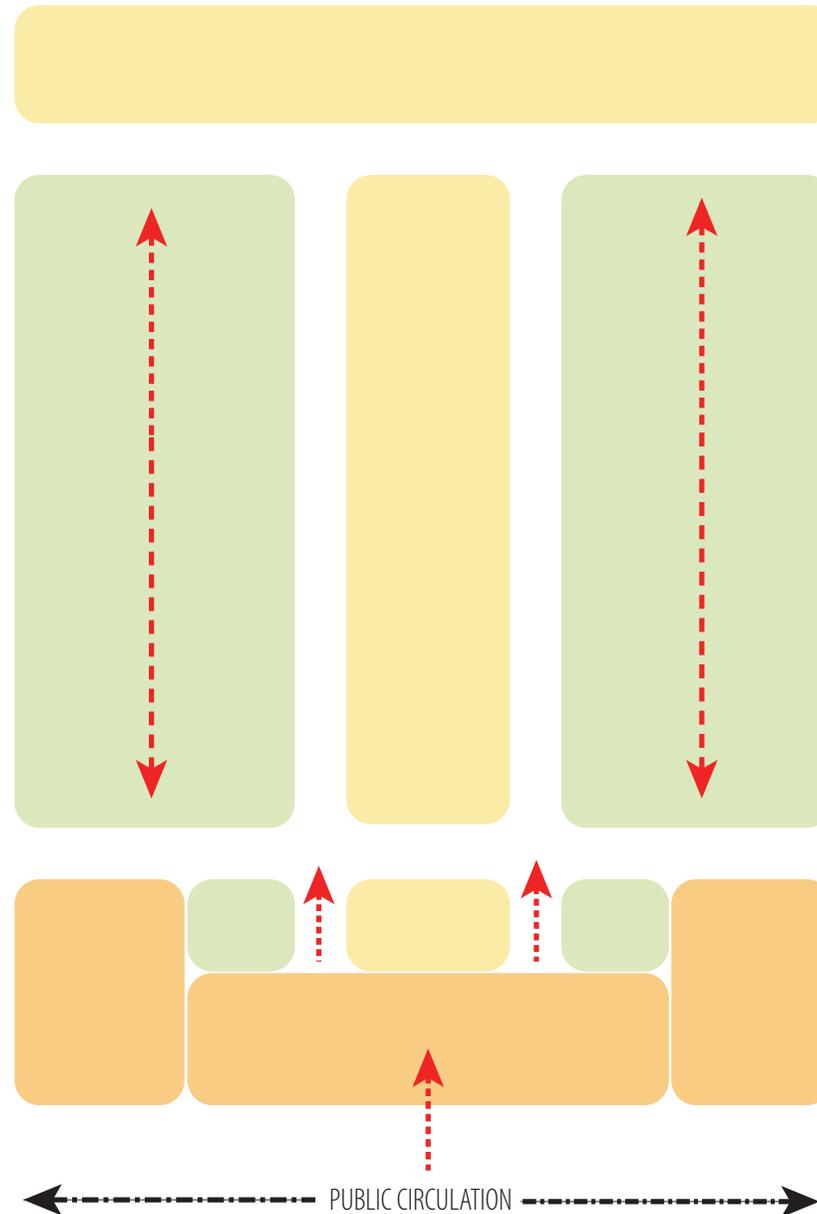
● STAFF



Small CBOC Prototype : Public/Patient Circulation

LEGEND - CIRCULATION

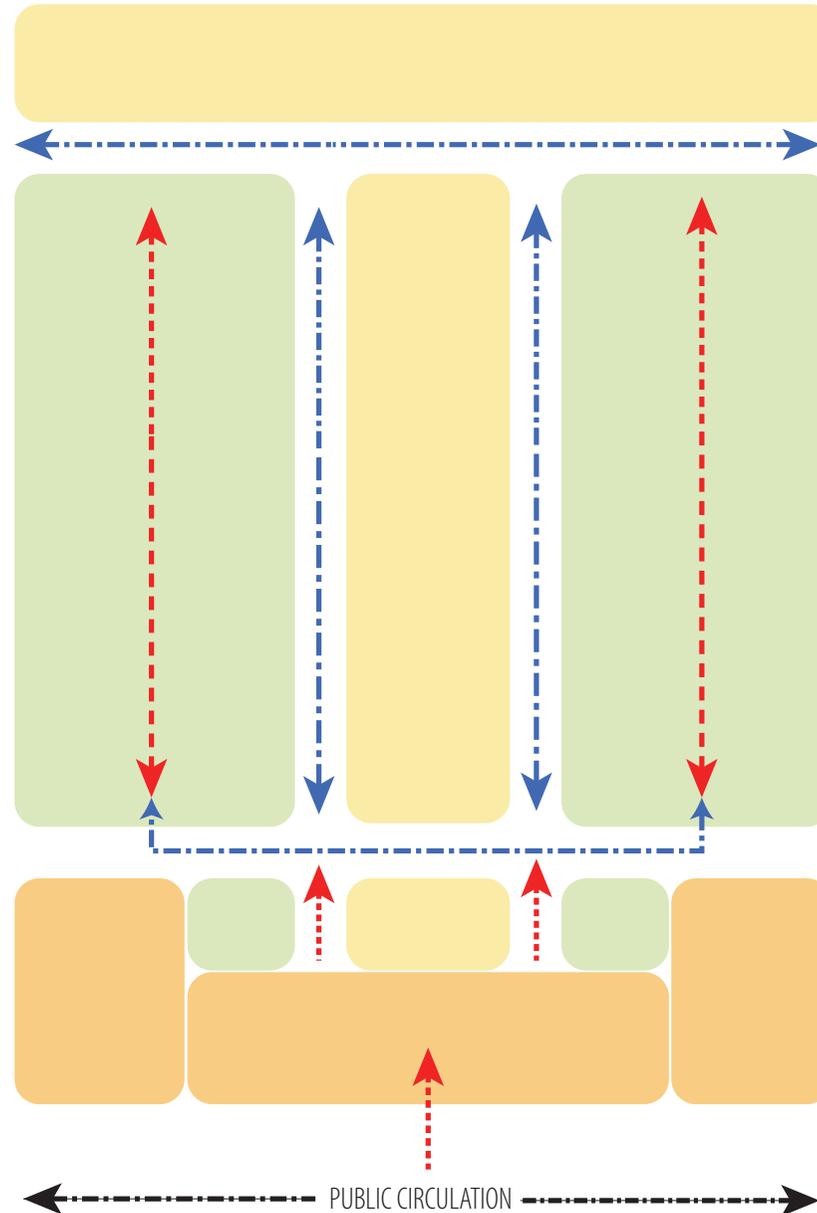
- ← - - - PATIENTS
- ← - - - STAFF
- ← - - - SECONDARY
- PUBLIC
- PATIENTS
- STAFF



Small CBOC Prototype : Patient/Staff Circulation

LEGEND - CIRCULATION

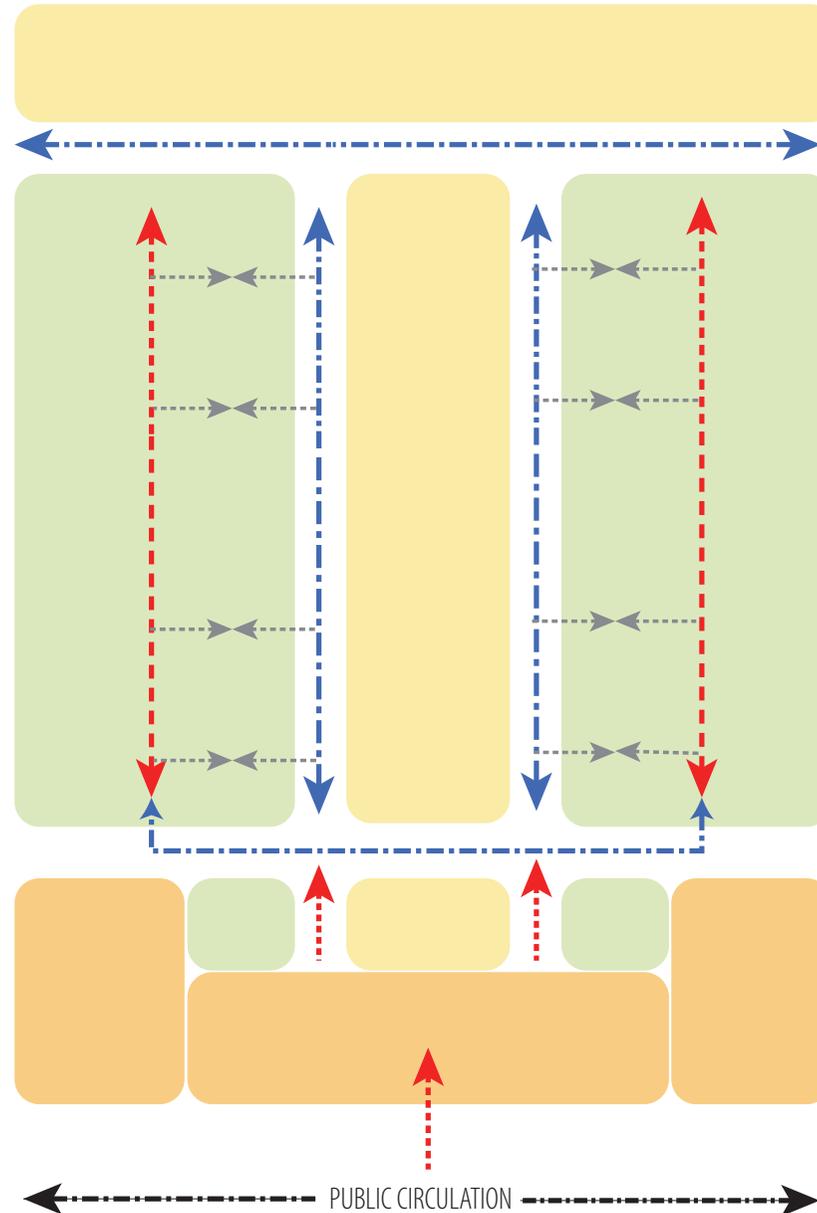
- ← - - - PATIENTS
- ← - - - STAFF
- ← - - - SECONDARY
- PUBLIC
- PATIENTS
- STAFF



Small CBOC Prototype : Secondary Circulation

LEGEND - CIRCULATION

- ← - - - PATIENTS
- ← - - - STAFF
- ← - - - SECONDARY
- PUBLIC
- PATIENTS
- STAFF



CBOC Prototype : Small

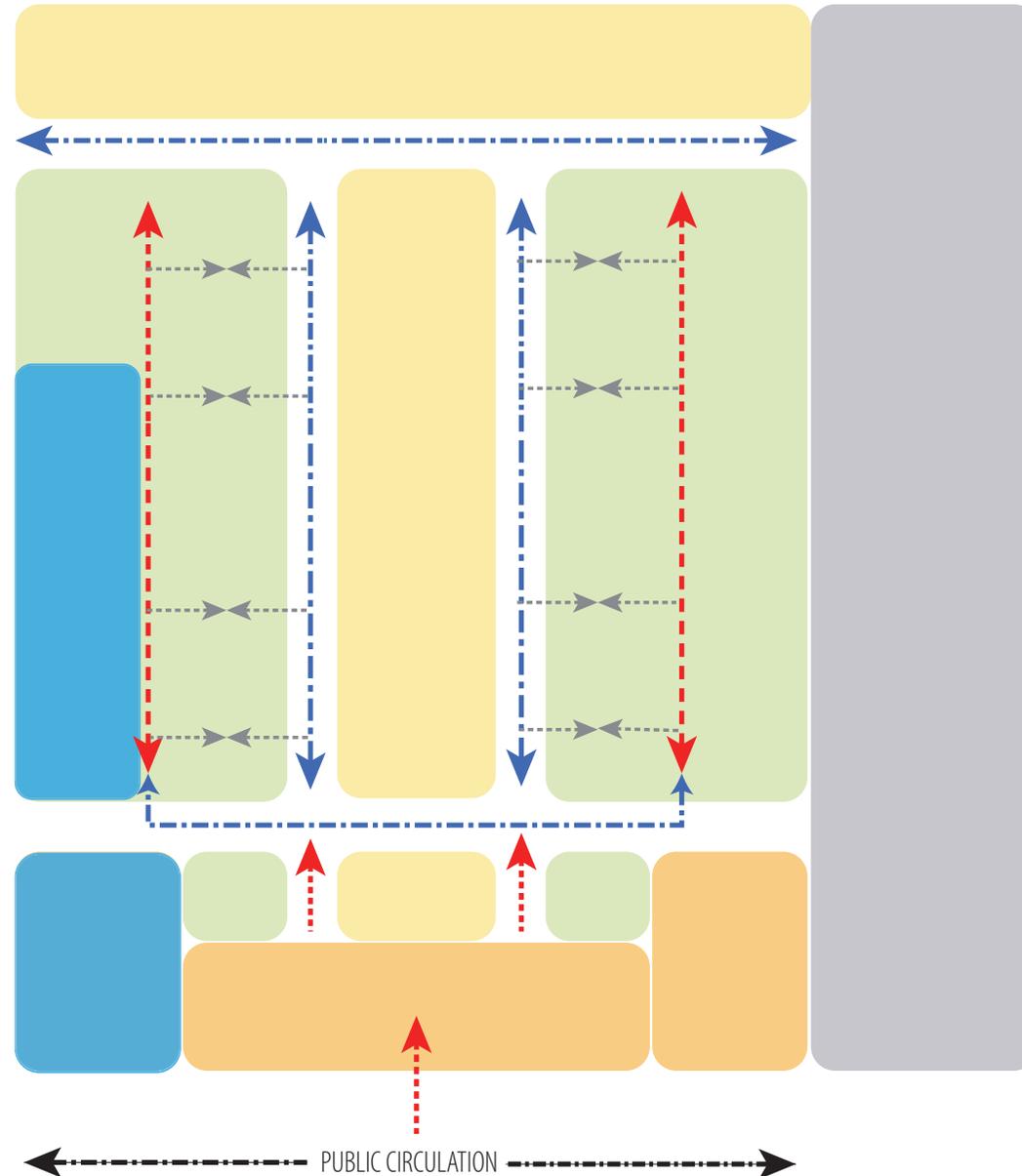
VA CBOC PROTOTYPE (SMALL)

Department	Net Area	Gross Area
Acquisition and Material Management Services (AMMS)	300	456
Patient Aligned Care Team (PACT) Module #1	5,860	8,907
Canteen	150	228
Mental Health	1,020	1,550
Pathology and Laboratory Medicine	160	243
Pharmacy	100	152
Sum of Departments	7,590	11,537
Building Gross Factor		1.25
TOTAL BGSF	0	14,421

Small CBOC Prototype : Block/Circulation Diagram

LEGEND - CIRCULATION

- ← - - - PATIENTS
- ← - - - STAFF
- ← - - - SECONDARY
- PUBLIC
- PATIENTS
- STAFF
- MENTAL HEALTH



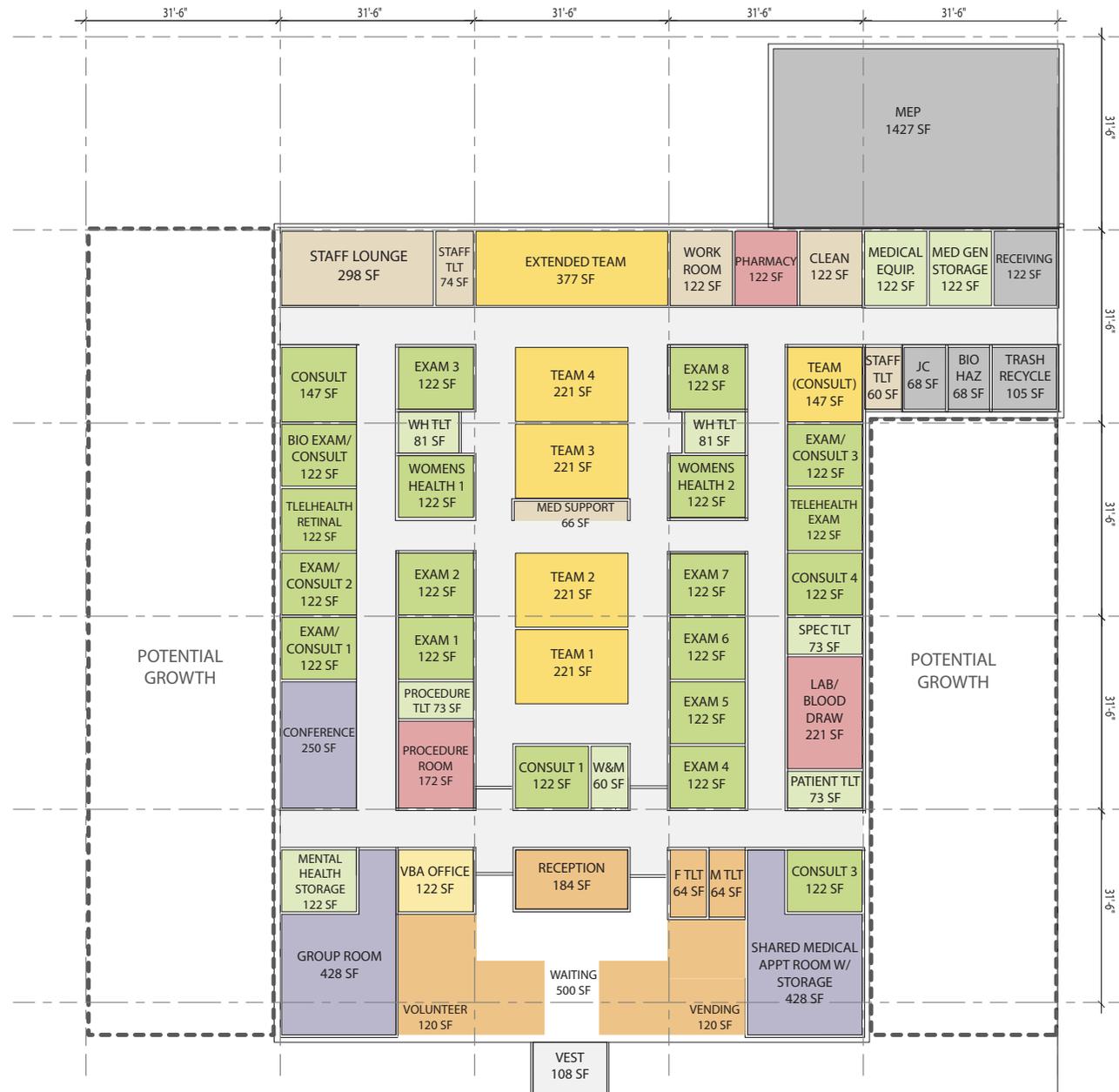
Key Highlights from Day 1

- Consult rooms will be programmed 125 SF, vice 120 SF per current criteria
- Every universal room will have data and plumbing capabilities
- Hamper included in the procedure room and exam rooms, replaces the need for Soiled Utility
- Regulated medical waste is addressed and stored in Biohazard storage located in the Materials Management area
- Volunteer Alcove- approx. 120 SF + Wheelchair storage 60 SF
- VBA – one shared office included
- Lab – follow paradigm for the Medium CBOC
 - Keep blood draw room for patients coming solely for routine tests
 - Phlebotomist goes to patient room when blood draw is required during encounter
 - Specimen toilet added with sink outside in the lab room
 - Patient toilet with specimen pass-through
- 2 additional equipment alcoves located in clinic corridor. Med prep alcove with under counter refrigerator for immunizations
- Patient Kiosks will be included in the waiting area with a privacy screen

Small CBOC Prototype : Option 1

LEGEND - FUNCTION

- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION/WAITING / PUBLIC SPACE
- EXAM/ CONSULT ROOMS
- TREATMENT/ PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- PATIENT SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Small CBOC Prototype : Option 1a

LEGEND - FUNCTION

- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION/WAITING / PUBLIC SPACE
- EXAM/ CONSULT ROOMS
- TREATMENT/ PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- PATIENT SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



CBOC Prototype : Medium

VA CBOC PROTOTYPE (MEDIUM)

Department	Net Area	Gross Area
Acquisition and Material Management Services (AMMS)	860	1,307
Patient Aligned Care Team (PACT) Module #1	5,860	8,907
Patient Aligned Care Team (PACT) Module #2	5,860	8,907
Audiology and Speech Pathology	1,600	2,432
Canteen	790	1,201
Home-Based Primary Care	600	912
Engineering	200	304
Eye Clinic	950	1,444
Mental Health	1,900	2,888
Pathology and Laboratory Medicine	710	1,079
Pharmacy	1,055	1,604
Physical Medicine and Rehabilitation	1,095	1,664
Police and Security	220	334
Prosthetics and Sensory Aids	800	1,216
Radiology	770	1,170
Sum of Departments	23,270	35,370
Building Gross Factor		1.25
TOTAL BGSF	0	44,213

Medium CBOC Prototype : Option 1

LEGEND - FUNCTION

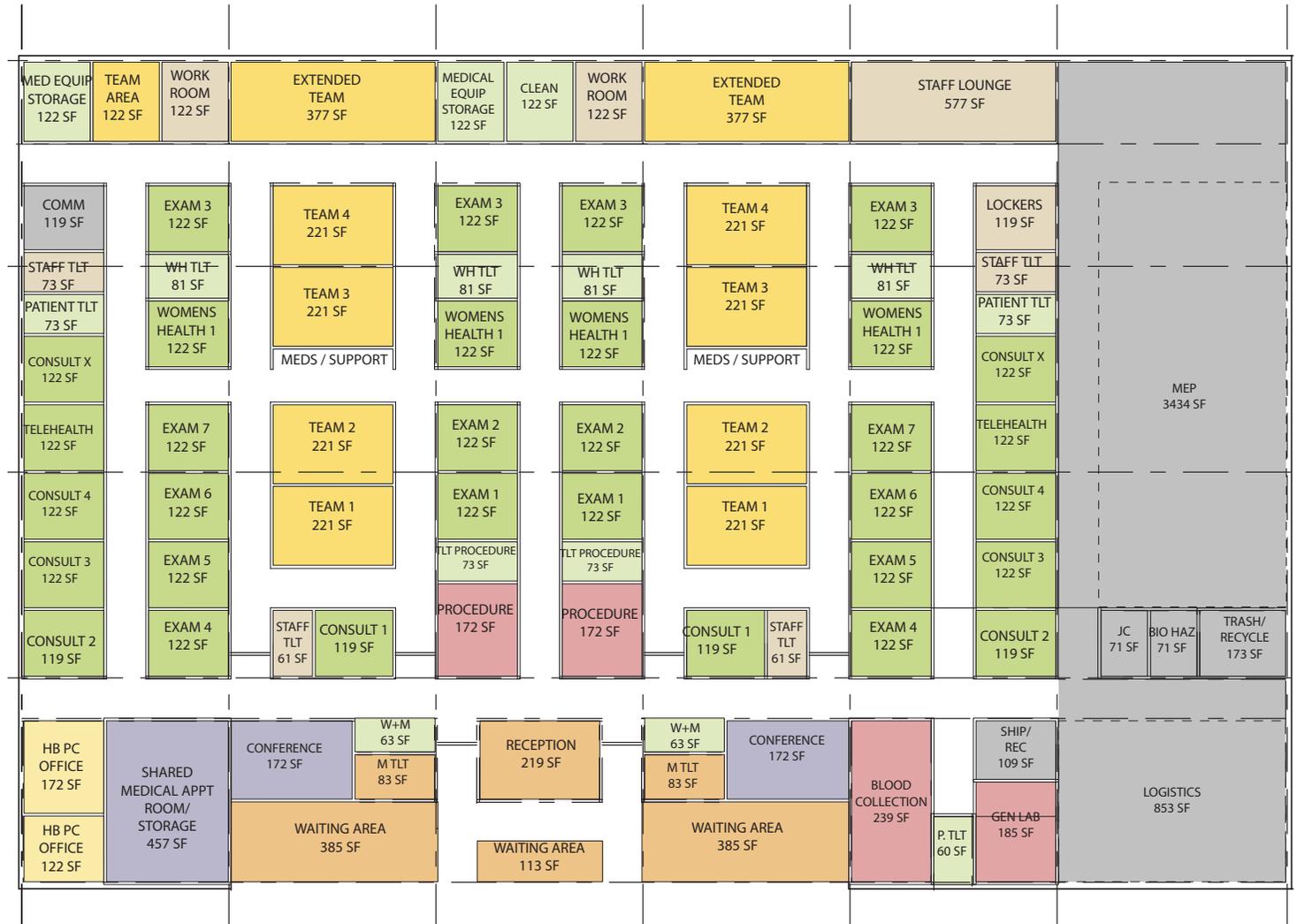
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Option 2

LEGEND - FUNCTION

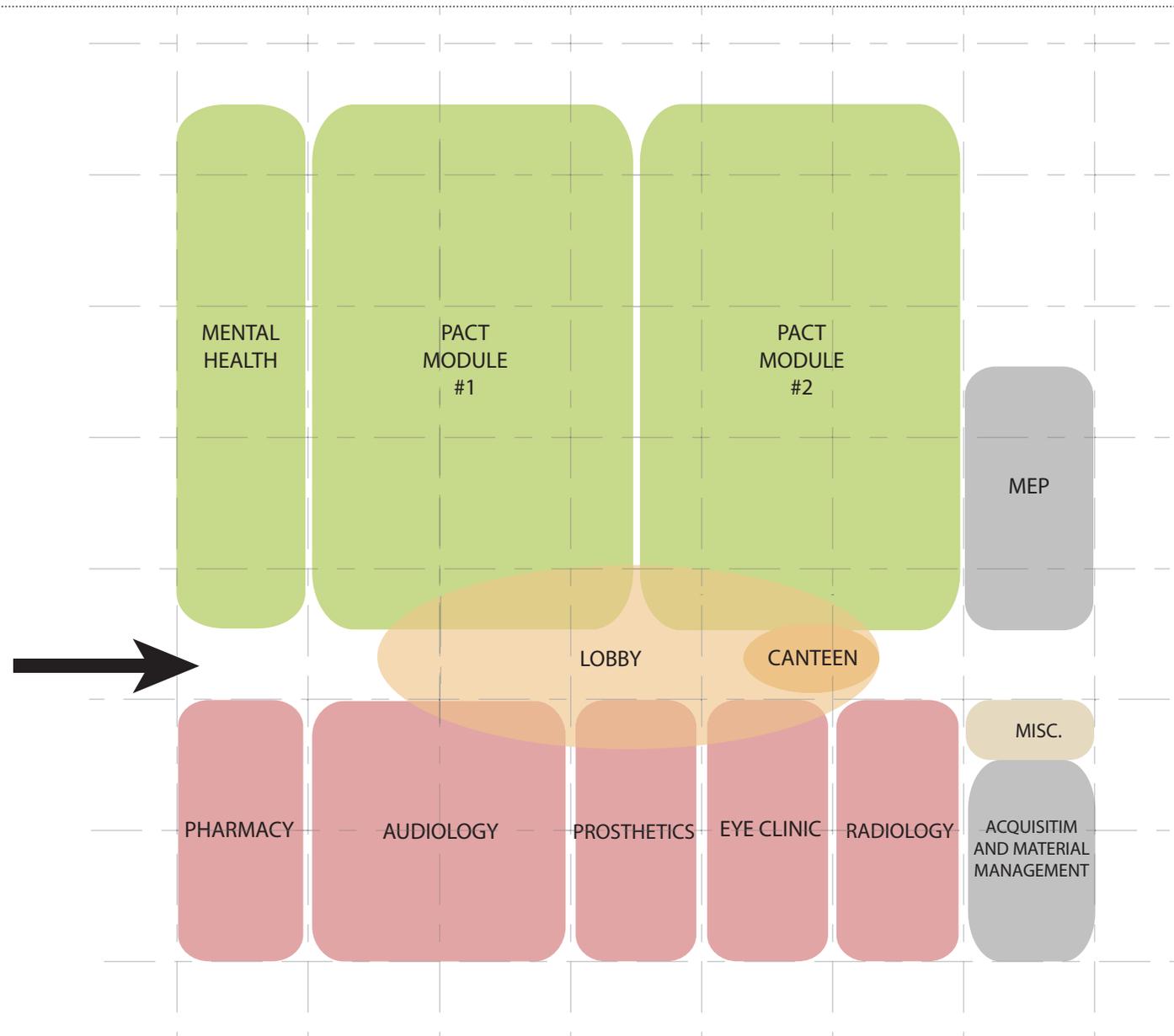
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 1

LEGEND - FUNCTION

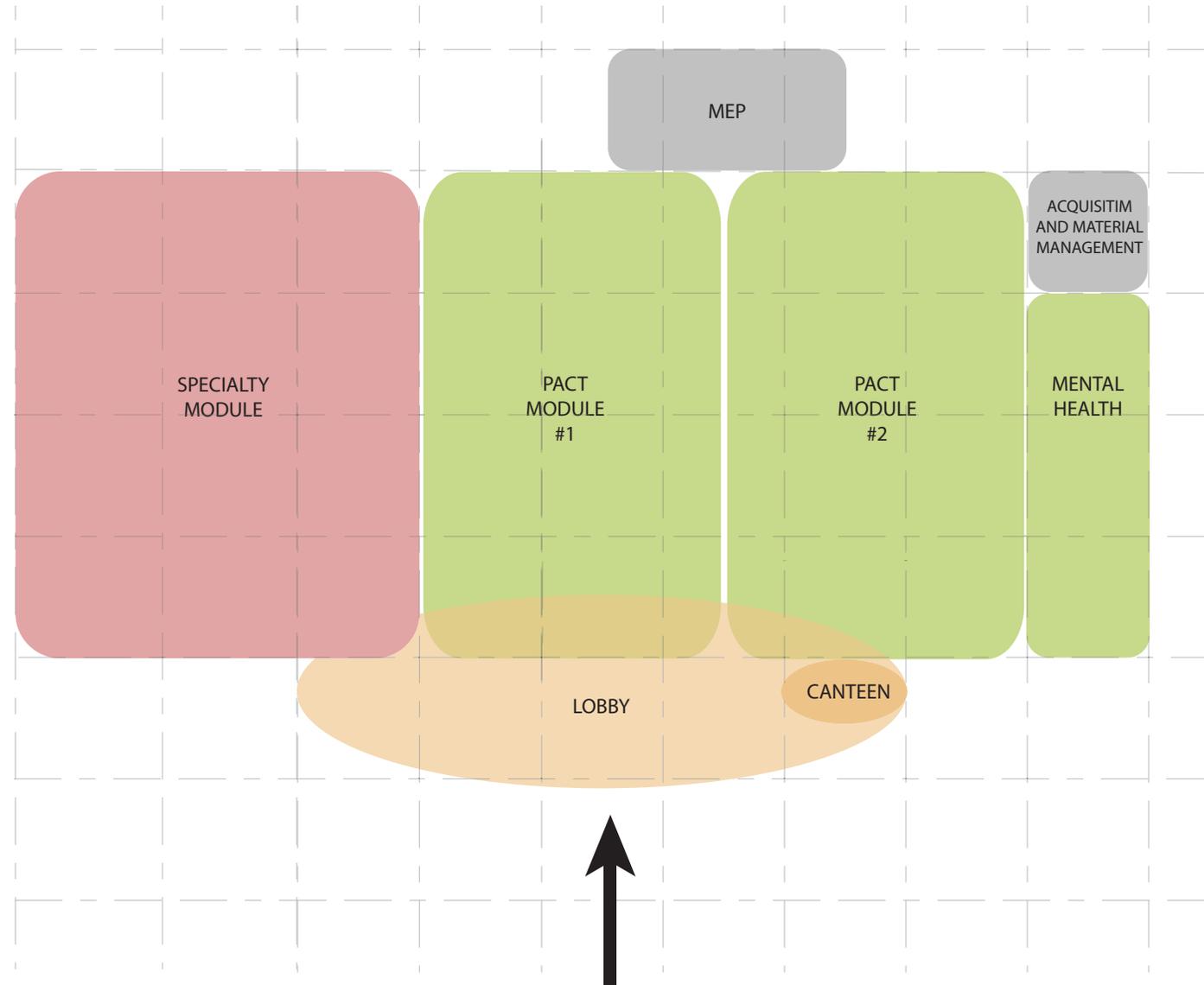
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 2

LEGEND - FUNCTION

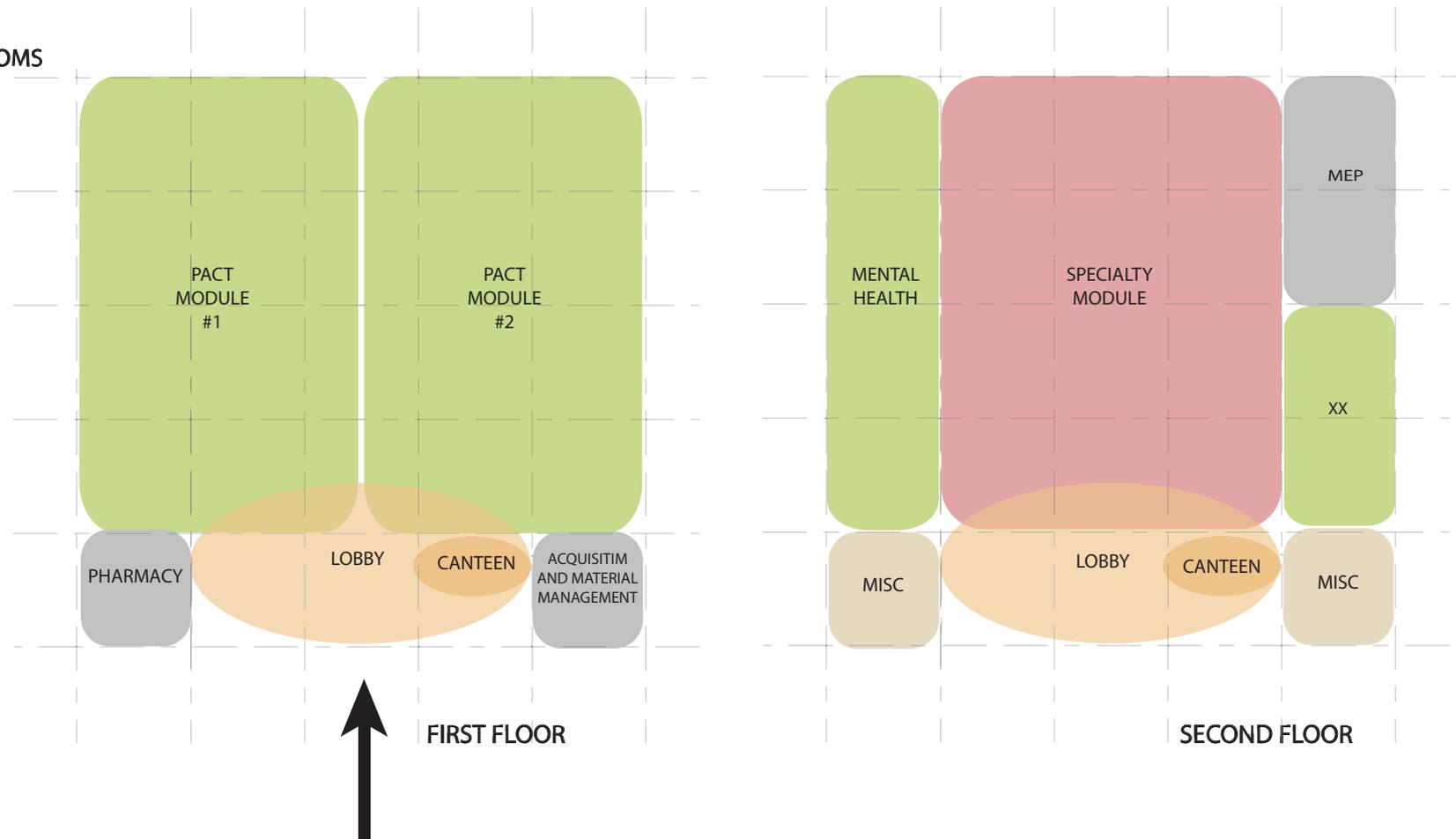
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 3

LEGEND - FUNCTION

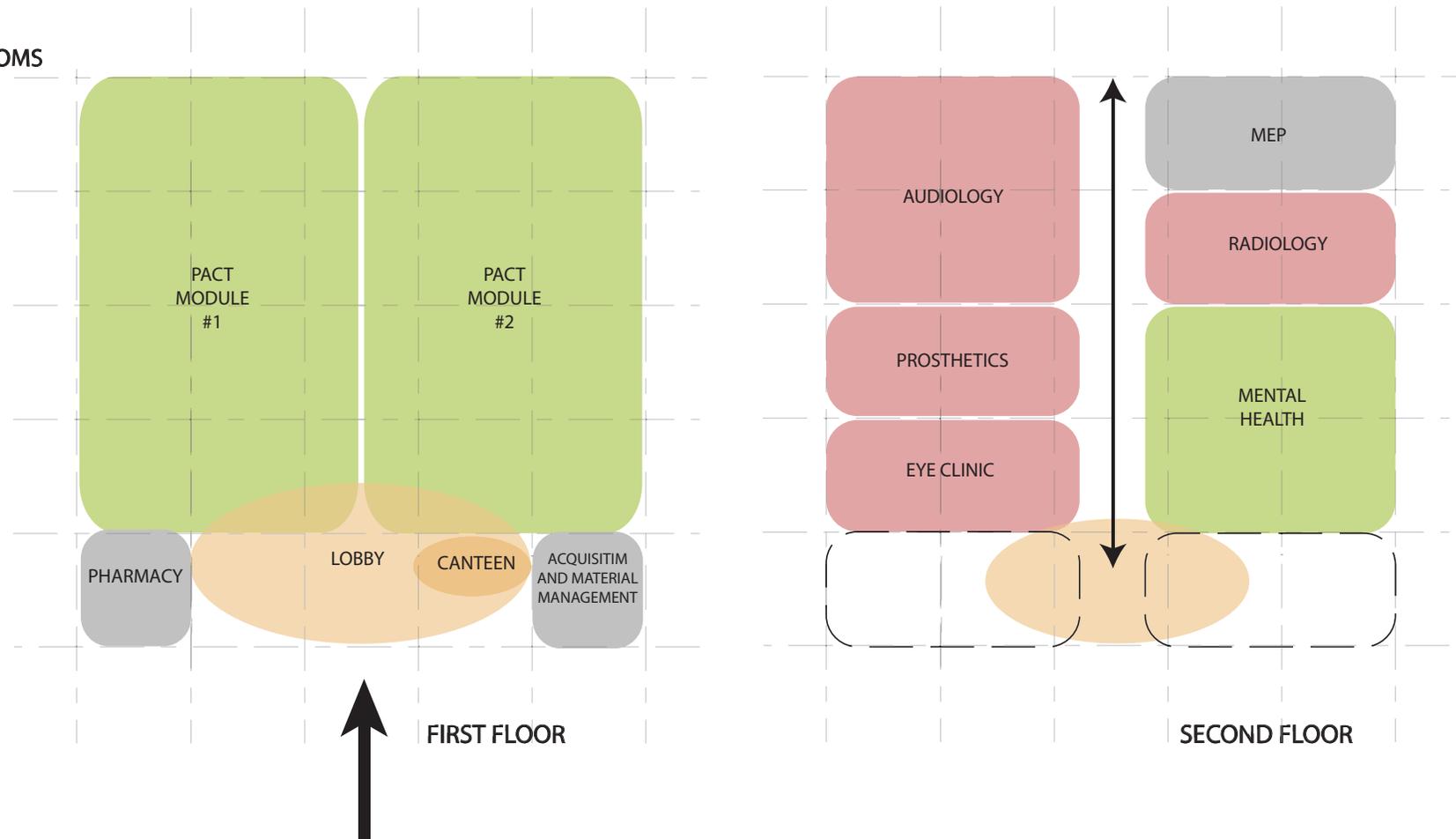
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 3a

LEGEND - FUNCTION

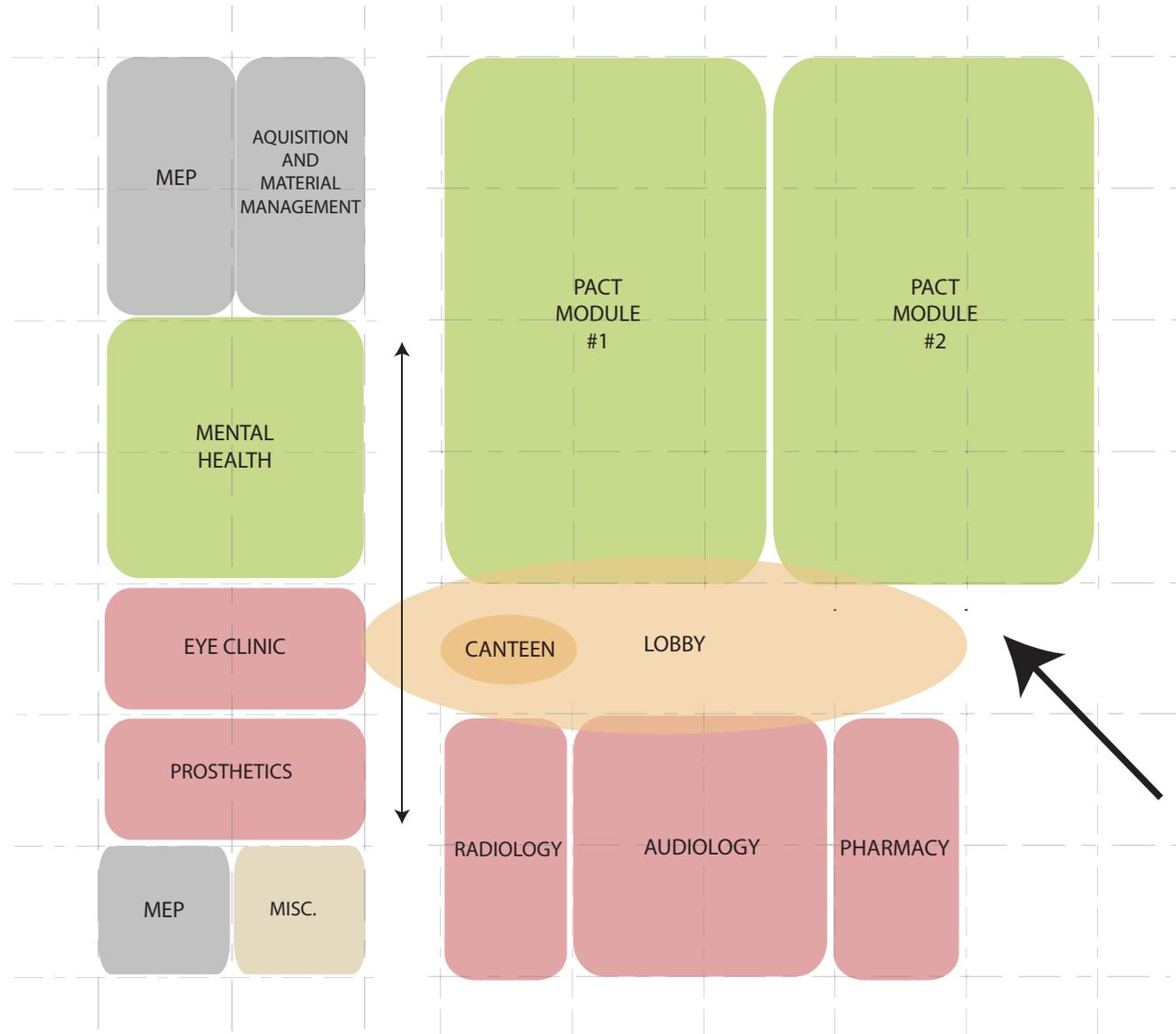
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 4

LEGEND - FUNCTION

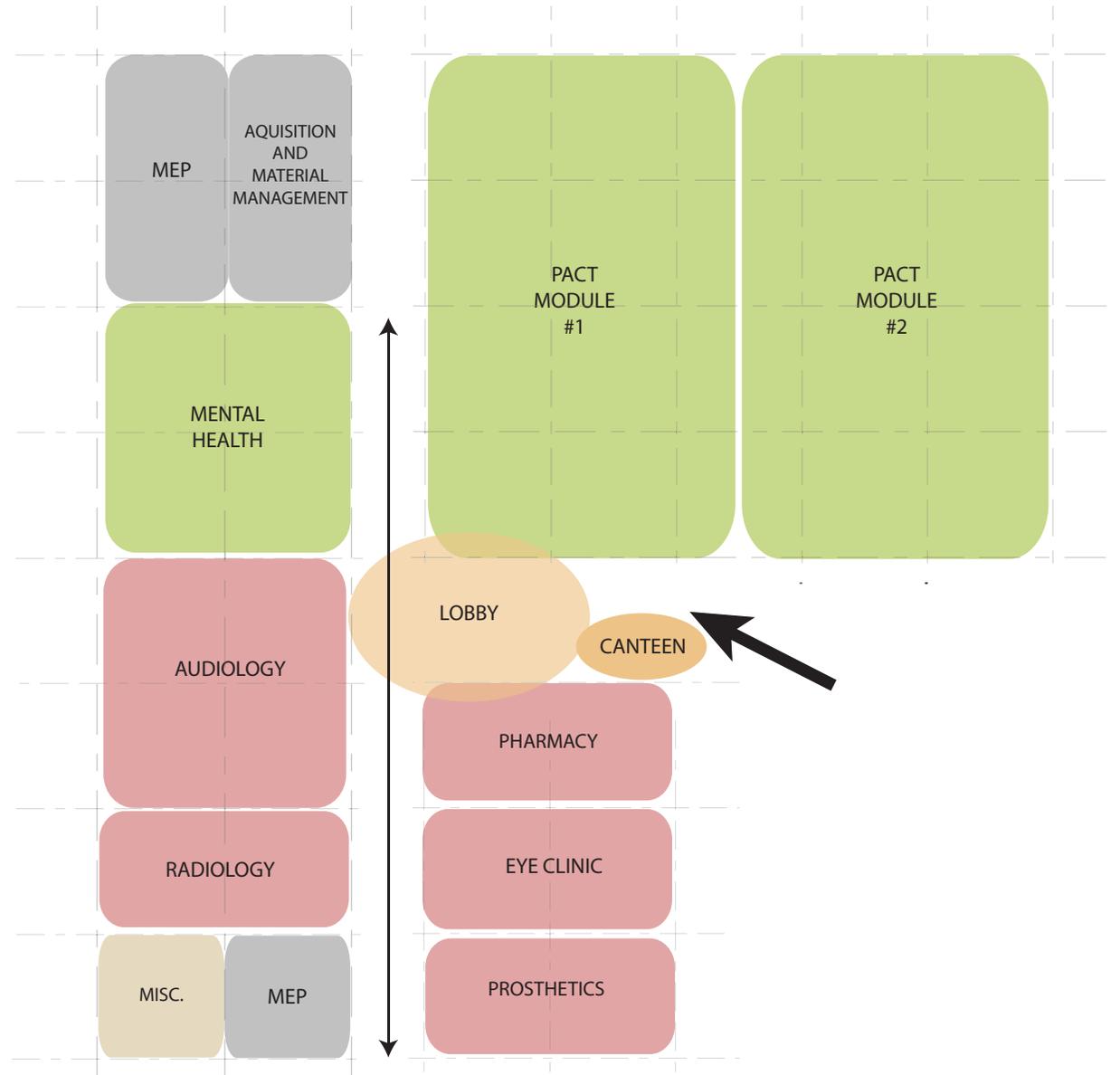
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 5

LEGEND - FUNCTION

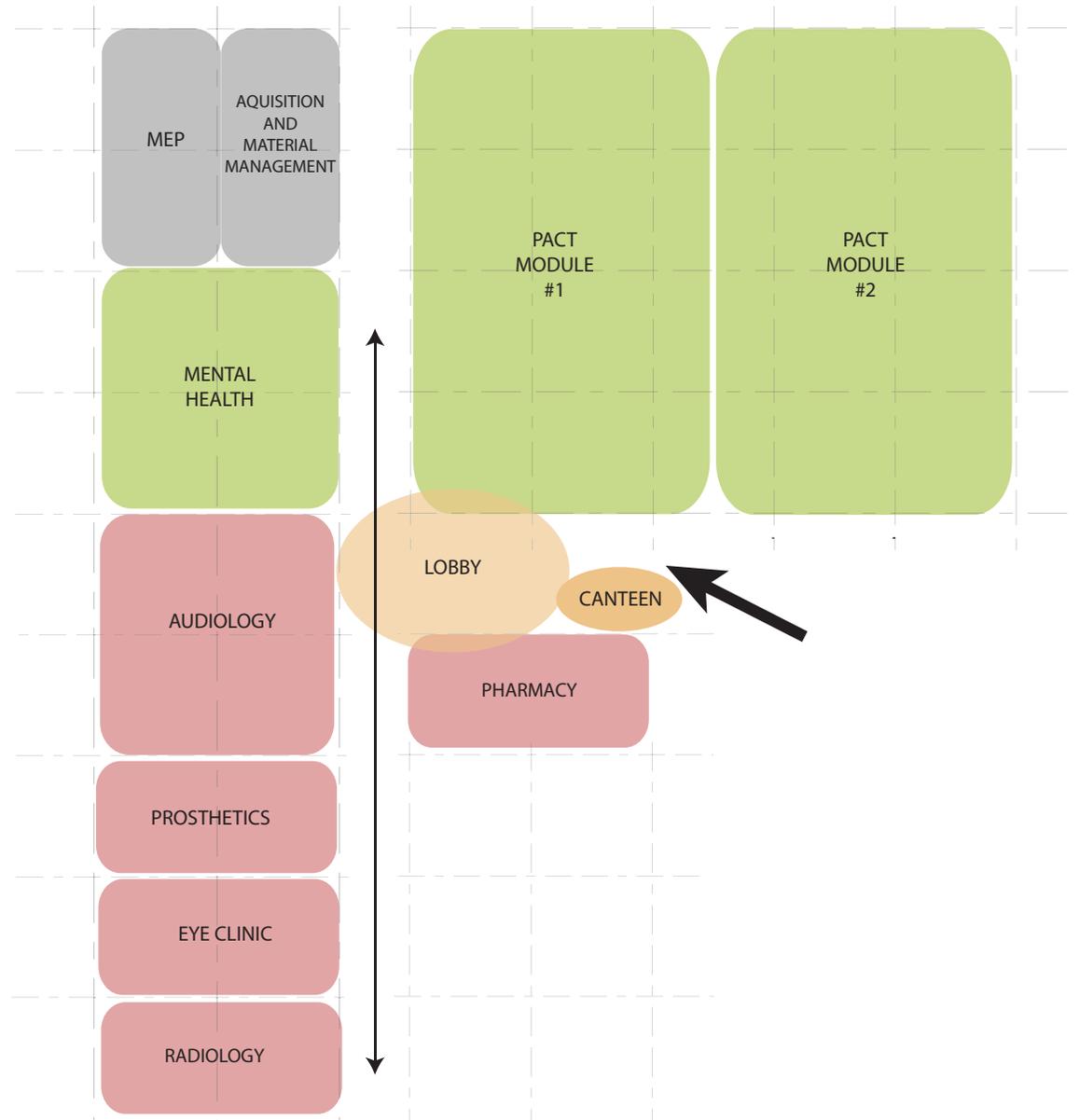
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Medium CBOC Prototype : Block Diagram - Option 6

LEGEND - FUNCTION

- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
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- MECH, ELEC, PLUMB, COMM
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CBOC Prototype : Large

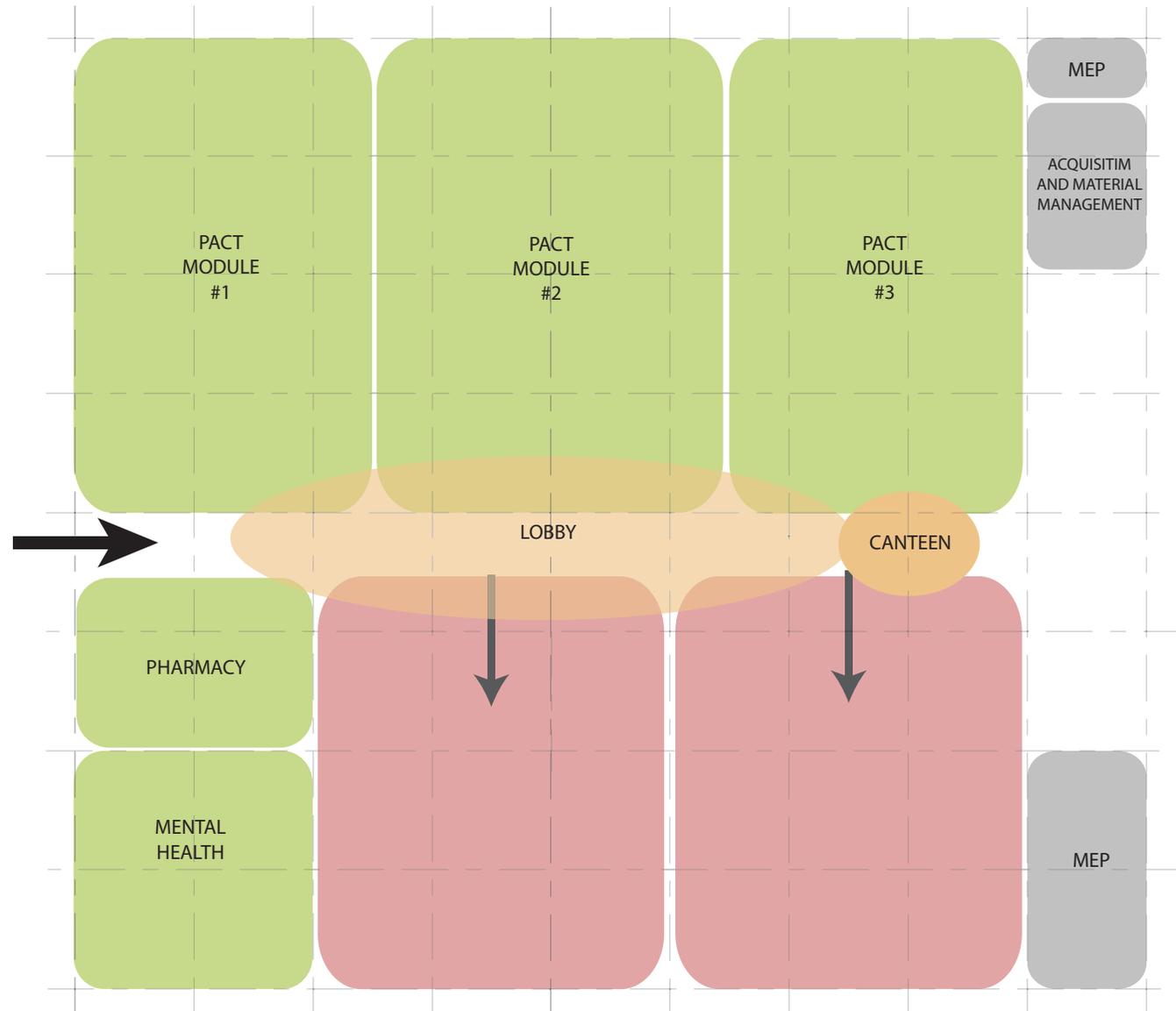
VA CBOC PROTOTYPE (LARGE)

Department	Net Area	Gross Area
Acquisition and Material Management Services (AMMS)	860	1,307
Patient Aligned Care Team (PACT) Module #1	5,860	8,907
Patient Aligned Care Team (PACT) Module #2	5,860	8,907
Patient Aligned Care Team (PACT) Module #3	5,860	8,907
Audiology and Speech Pathology	2,765	4,203
Canteen	1,240	1,885
Home-Based Primary Care	1,080	1,642
Dental	2,305	3,504
Engineering	200	304
Eye Clinic	1,190	1,809
Mental Health	2,680	4,074
Pathology and Laboratory Medicine	1,280	1,946
Pharmacy	1,794	2,727
Physical Medicine and Rehabilitation	1,640	2,493
Police and Security	220	334
Prosthetics and Sensory Aids	800	1,216
Multi-Specialty Clinic	2,950	4,484
Radiology	1,770	2,690
Sum of Departments	40,354	61,338
Building Gross Factor		1.25
TOTAL BGSF	0	76,673

Large CBOC Prototype : Block Diagram - Option 1

LEGEND - FUNCTION

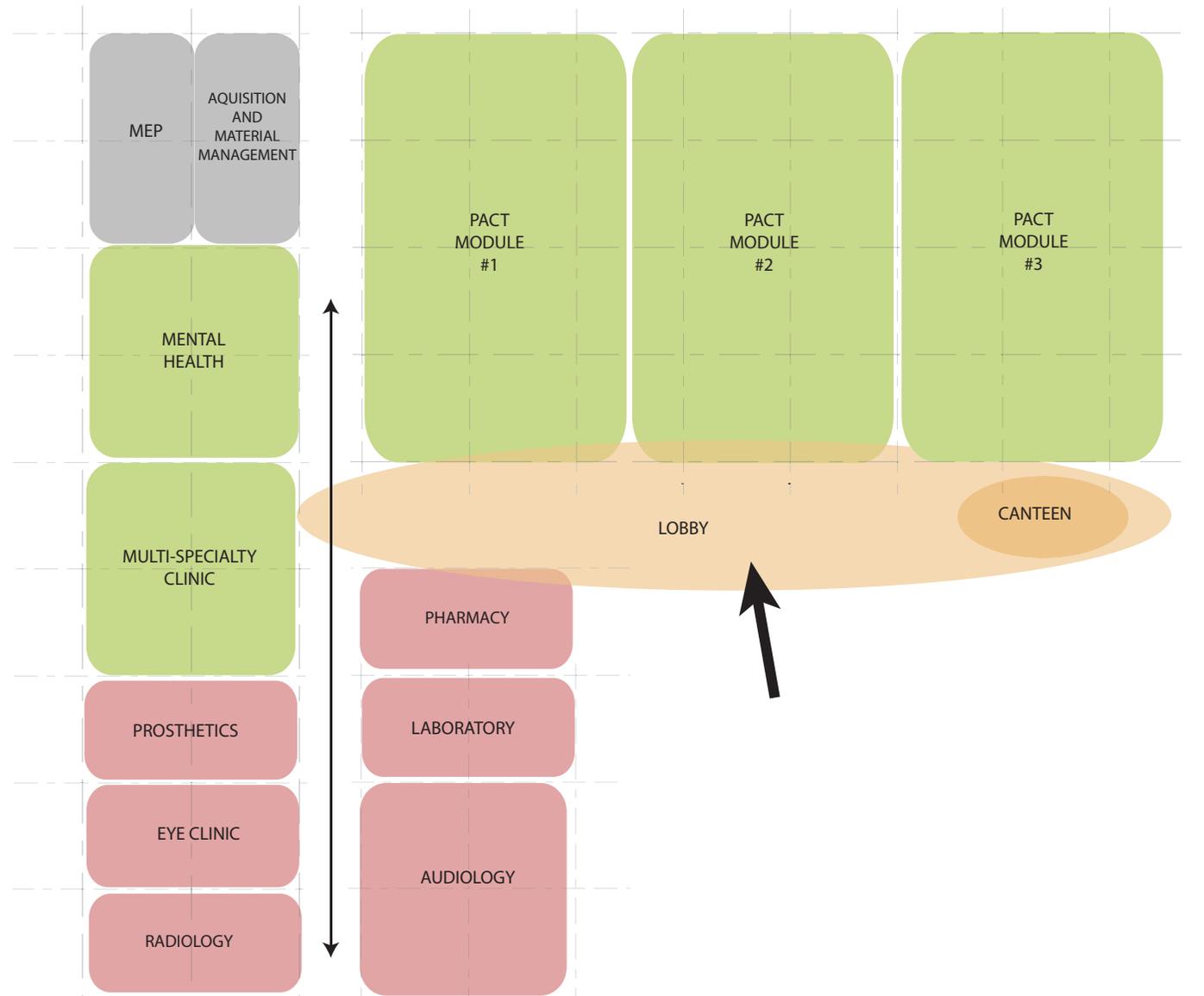
- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
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- CLINIC SUPPORT
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- CIRCULATION



Large CBOC Prototype : Block Diagram - Option 2

LEGEND - FUNCTION

- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM / CONFERENCE
- RECEPTION / WAITING / PUBLIC SPACE
- EXAM / CONSULT ROOMS
- TREATMENT / PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



Project Next Steps

Kick-off Meeting	21 August 2013
Hawaii Site Visit	16 - 20 September 2013
Minneapolis Site Visit	25 - 27 September 2013
Tampa Site Visit	1- 3 October 2013
Charrette in Washington DC [design modules and standard template design]	17 October 2013
Preliminary Submittal	1 November 2013
One Week Government Review and Comments	8 November 2013
Working Session #1 in Washington DC	13-14 November 2013
<i>Working Session #2 in San Francisco / Mare Island</i>	<i>10-11 December 2013</i>
<i>Progress Submittal</i>	<i>TBD January 2014</i>
Working Session #3 in Tampa	14-15 January 2014
Working Session #4 in Minneapolis	TBD 2014
Final Review and Presentation, Washington DC	TBD 2014



Design Charrette Agenda: Mare Island

Day 1: 10 December 2013

- 0830 - 0900 Arrive at VISN + Travel Time
- 0900 - 1100 DIRTT Modular Construction Tour
- 1100 - 1130 Travel Time
- 1130 - 1230 Lunch
- 1230 - 1300 Project Update
- 1300 - 1400 Review Prototypes
- 1400 - 1630 Working Session Small CBOC
 - test fit Maui CBOC
 - review and refine layouts and modules
 - program for design
- 1630 - 1700 Wrap-up

Day 2: 11 December 2013

- 0800 - 1200 Design Team Working Session
- 1200 - 1300 Lunch
- 1300 - 1330 Highlight Key Take Away from previous day
- 1330 - 1500 Working Session Medium CBOC
 - block & circulation diagrams
 - review and refine layouts and modules
 - program for design
- 1500 - 1515 Break
- 1515 - 1630 Working Session Large CBOC
 - block & circulation diagrams
 - review and refine layouts and modules
 - program for design
- 1630 - 1700 Wrap-up
 - Summarize options, address final comments and next steps

Progress Submittal Outline

Section 1 - Executive Summary

Section 2 - Project Narrative

Section 3 - CBOC Prototype Planning Assumptions

Section 4 - CBOC Prototypes Programs for Design

Section 5 - Planning Modules + Clinical Diagrams

Section 6 - CBOC Proposed Layouts

Section 7 - VA Test-fit Programs for Design

- VISN 21 - Maui, HI
- VISN 23 - Rapid City, MN
- VISN 8 - Brooksville, FL

Section 8 - Off-Site Construction Methods + Impact

Section 9 - Cost Estimates

Section 10 - Appendix

- Glossary of Terms
- Abbreviations
- References
- Appendix A (Local VISN Site Visits)
- Meeting Minutes

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 22 November 2013
 Meeting Date 19 November 2013
 Location Conference Call
 Purpose Bi-weekly Project Update

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	Director of Cost Estimates, CFM	202-632-5614	Jay.sztuk@va.gov
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Tracy Bond	SmithGroupJJR, Project Manager/Architect/Medical Planner	202-974-5161	tracy.bond@smithgroupjjr.com
Gabryela Passeto	SmithGroupJJR, Architect/Medical Planner	202-974-0830	gabryela.passeto@smithgroupjjr.com
Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com

ITEM DISCUSSION ACTION

1.0 Project Update – 1400

Attendees: Jay Sztuk, Ding Madlansacay, Pete Yakowicz, Dr. Denietolis, Tracy Bond, Gabryela Passeto and Chris Phillips

- 1.1 Tracy began the meeting by acknowledging receipt of Jay's e-mail sent earlier in the day:
 - IT issues need to be resolved prior to the call and meetings need to start on time so that those calling in are not waiting on the phone.
 - Jay wants interactive tools used for the charrettes and changes be shown in real time for all participants to be able to see
 - Tracy added that to this point, it was not appropriate to use those tools, but agreed that in future charrettes, as the study progresses, interaction will be incorporated.
- 1.2 Two possible showrooms displaying healthcare modular construction is available for the team to visit while in San Francisco
 - Gabryela proposed the DIRT tour take place on the afternoon of December 9th as people are flying in for the charrette
 - Participants interested in attending will confirm travel arrangements with Gabryela for a final head count
 - Jay asked how many would be interested in visiting the second facility on Thursday following the charrette
 - Tracy added that SmithGroupJJR and The Innova Group would not be attending during this trip since it is not supported within our current project scope. However, SmithGroupJJR and INNOVA do have frequent travel to the San Diego area and will be able to visit that facility late January or February.
- 1.3 Chris Phillips informed participants of the requested changes to the Programs for Design from the two day working session in Washington, DC.
 - The following changes were agreed to at the working session:
 - Consult Rooms will increase from 120 sf to 125 sf
 - Every universal room will include a sink and data capability to support tele-medicine
 - Three administrative offices will be added to the Medium and Large prototypes to allow for any administrative office needs they may require
 - A second Tele-Medicine Room will be added to the PACT and will be setup for use

- as a Tele-Retinal Room
 - Dental operatories will increase from 120 sf to 125 sf
 - A Volunteer Alcove @ 120 sf will be added to each prototype; Adjacent to that will be an added Wheelchair Storage Area of 60 sf in the Small, 90 sf in the Medium and 120 sf in the Large prototypes.
 - The Point of Care Testing (POCT) Lab and single phlebotomy station in the small prototype will be separated and increased to two blood draw stations and a POCT Lab.
 - The following recommended changes were referred for decision with other stakeholders:
 - It was requested that Mental Health should follow the PACT guidelines and should therefore work out of team rooms with counseling rooms embedded throughout the primary care area. The question is for each prototype small, medium, and large are mental health providers only embedded within primary care or is there a more robust mental health component that would be considered separate from primary care? If the mental health providers are embedded in primary care, it was assumed that they would be housed in team rooms and provided Consult Rooms for patient encounters. If they are a separate service, it is unclear if the mental health providers would be seeing patients in their dedicated office or if they would be housed in team rooms and be provided Consult Rooms for patient encounters. A follow-on meeting was established to talk with VA Mental Health subject matter experts.
 - It was stated that the draft PACT criteria allocation method for Women's Health Exam Rooms may be too robust. The criteria calls for a four teamlet PACT Module to have 12 exam rooms of which 2 should be Women's Health with attached toilets. Upon viewing the eight teamlet two-Pact Module configuration, it was stated that one Women's Health Exam Room may be sufficient even for two PACT Modules. There was no clear resolution to this inquiry and it will be referred to a VA Women's Health subject matter expert for decision.
- 1.4 Jay asked a question to the group to see how they felt the project was progressing overall:
- Pete added that he and the Rapid City folks are anxious to delve into the kit of parts, but understand the process and importance of developing the Prototypes beforehand
 - Tracy added that the success of the next working session will inform us on the design, modules and timeline going forward since the past meetings have been defining the programs for these prototypes. If these next working sessions are productive with a clear direction, the team will have no problem meeting the completion date in March.
 - Jay would like to see simulations for different types of patients and more work flow diagrams at the next charrette.
- 1.5 Gabryela will be submitting meeting minutes from last week's charrette by COB on next Monday.
- 1.6 Tracy requested a copy of the current PACT drawings and layouts that are being worked concurrently with another A/E firm. Gary Fischer was the POC for that request earlier in the project. Jay raised a good question to the steering group regarding his observation that during our initial site visits most staff were absent from the clinics since most were attending a PACT training course. He asked what kind of training are they receiving and whether it would be of benefit to meet with them.
- Angie stated that the type of training they are receiving is not based on the design of the clinic in any way, but rather basic concepts of operations and access
 - Angie does lead that group and has offered to share with us the type of training they receive if the group is interested.
- 1.7 Chris Phillips pointed out the importance of tracking the program changes from the group back to the draft PACT space planning criteria. Recommended changes so far include things like increasing Consult Rooms from 120 sf to 125 sf; adding a second Tele-medicine Room to the PACT Module; and confirming the number of Women's Health Exam Rooms to be in each PACT Module.

1.8 Next Steps:

- Jay will be setting up a meeting with the Mental Health Integration decision makers for this week.
- The design team will begin looking at the specialty care modules
- Design team is preparing for the 2-day Charrette #2 in Mare Island on 10-11 December 2013

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 26 November 2013
 Meeting Date 21 November 2013
 Location Teleconference
 Purpose Defining Space Program – Primary Care Mental Health Integration

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.sztuk@va.gov
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Gary Fischer	VA CFM, Senior Healthcare Architect	202-632-4898	Gary.fischer@va.gov
Dr. Ward Newcomb	PCS, 10P4F, PACT Space	334-221-5353	William.newcomb@va.gov
Dr. Angela Denietolis	James A. Haley Veteran's Hospital, ACOS Ambulatory Care	813-972-2000 ext. 6209	Angela.denietolis@va.gov
Dr. Edward Post	National Medical Director, Primary Care Mental Health Integration	734-845-3579	Edward.Post@va.gov
Mary Schohn	Director, Mental Health Operations	202-461-6990	Mary.schohn@va.gov
Lisa Kearney	Mental Health Technical Assistant	210-694-6222	Lisa.kearney3@va.gov
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Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com

ITEM DISCUSSION ACTION

1.0 Space Programming: Mental Health – 0400 - 0530

Attendees: Jay Sztuk, Linda Chan, Dr. Newcomb, Dr. Denietolis, Dr. Post, Mary Schohn, Lisa Kearney, Gabryela Passeto and Chris Phillips

1.1 Jay began the discussion giving a brief project background to Lisa Kearney, Mary Schohn and Dr. Post. He is looking to the decision makers for their guidance to make a decision about Mental Health Integration within the Small, Medium and Large CBOC Prototypes.

1.2 Chris set the stage and presented the problem statement:

- During a recent CBOC template design charrette, there were concerns raised about the rooms provided for Mental Health. It was requested that Mental Health should follow the PACT guidelines and should therefore work out of team rooms with counseling rooms embedded throughout the primary care area. For each prototype Small, Medium, and Large: Are mental health providers only embedded within primary care or is there a more robust mental health component that would be considered separate from primary care? If the mental health providers are embedded in primary care, it was assumed that they would be housed in team rooms and provided Consult Rooms for patient encounters. If they are a separate service, it is unclear if the mental health providers would be seeing patients in a dedicated office/counseling room or if they would be housed in team rooms and be provided Consult Rooms for patient encounters. A follow-on meeting was established to talk with VA Mental Health subject matter experts.
- The purpose of this meeting is to identify whether the Mental Health service is embedded in primary care or if it is a separate service in the three different sized prototypes. If separate, are the Mental Health providers housed in team rooms and use Counseling Rooms only for patient encounters; or is each provider given a dedicated Office/Counseling Room?
- Current criteria for Mental Health (dated 2008) allows for an Office/Counseling Room for each Mental Health provider. Is this criteria out of touch with latest VA guidance and intent? The draft PACT space planning criteria calls for an Extended Team Room and Consult Rooms for those providers embedded with the PACT.

- 1.3 Dr. Newcomb stated that embedded mental health means different things to different people. Dr. Post offered his expertise on the matter:
- In a small setting, tertiary care is still offered to veterans. Typically a psychologist is embedded within PACT and share some space within the clinic and utilize the non-assigned consult rooms
 - The administration has requested and is pushing for tertiary psychiatry care to also be integrated – not within PACT, but also not so far away that ‘warm hand-offs’ can’t be done
- 1.4 Gabryela reviewed the preliminary layouts that were presented in the charrette the previous week. She showed examples of mental health being integrated within PACT and as a separate module altogether via bubble diagrams to help foster the discussion.
- Mary Schohn asked what is the normal intent for furnishing the consult rooms for Mental Health
 - Dr. Newcomb answered the rooms would have a documentation station for the provider and a comfortable chairs for patients and family members versus the typical office/exam model where there is a large desk for a provider in their private office and chairs for patients
 - Dr. Post asked for a brief description of the patient experience within the clinic.
 - Dr. Denietolis walked Dr. Post through a typical patient encounter using the PACT model of care
 - Dr. Post asked if it makes sense to include tertiary psychiatry within this model. Dr. Denietolis added most large facilities cannot accommodate tertiary psychiatry.
 - Dr. Post offered the ideal layout for Mental Health within PACT
 - A dedicated room for the psychiatrist would be ideal
 - The social worker and psychologist would flex between the consult rooms. This is difficult if they vary day to day versus being fixed or dedicated rooms because it doesn’t foster the ‘warm hand-off’ policy if they are in separate corridors at different ends of the clinic.

2.0 Other Considerations:

- 2.1 Dr. Post suggested to the design team that we may be over allocating space for mental health:
- 2.2 Should mental health have a dedicated staff POD or teamlet?
- Mary stated there wouldn’t be a 4 person teamlet covering 1 PACT team
- 2.3 Lisa Kearney stated that mental health is not a specialty care in this setting. She inquired about where this type of care is being done as the steering group is proposing.
- Dr. Denietolis added the PCA in Tampa is the closest project currently under construction that will emulate this model of care with mental health integration.

3.0 Discussion Outcome and Next Steps:

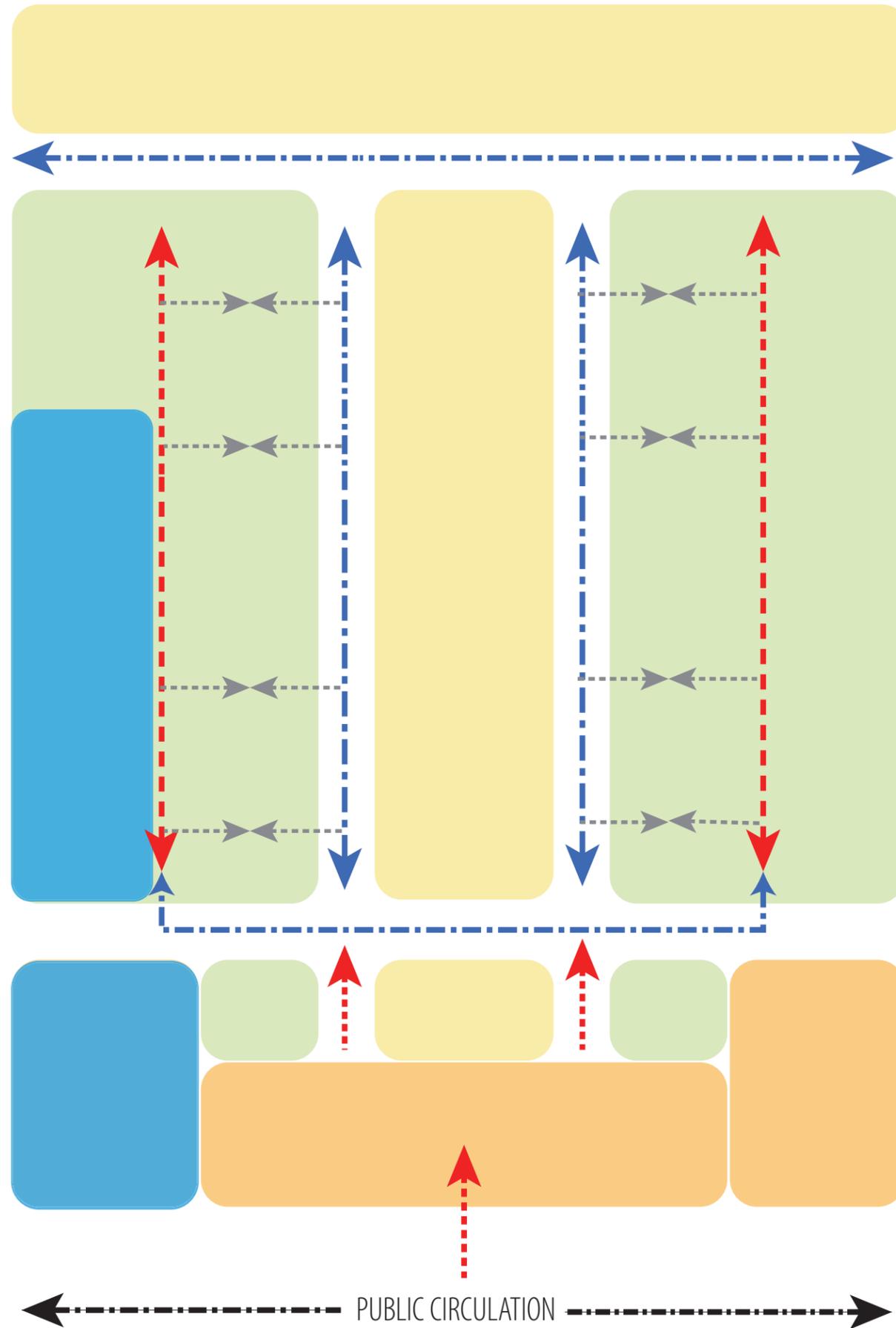
- 3.1 4,800 patients require a maximum of 3 mental health providers. A psychologist is already embedded are part of the BHIP program.
- Two consult rooms would be utilized by the psychologist and social worker. The psychiatrist would have a touchdown area
 - Enlarge the ‘extended team room’ for additional visiting providers such as psychiatrist. A ‘teamlet’ for mental health is not appropriate as it is not defined the same due to the nature of the care
- 3.2 Follow-up with participants for a time to discuss Mental Health as a separate module.
- Jay will coordinate and set-up this call with the end users

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

LEGEND - CIRCULATION

- ← - - - PATIENTS
- ← - - - STAFF
- ← - - - SECONDARY
- PUBLIC
- PATIENTS
- STAFF
- MENTAL HEALTH



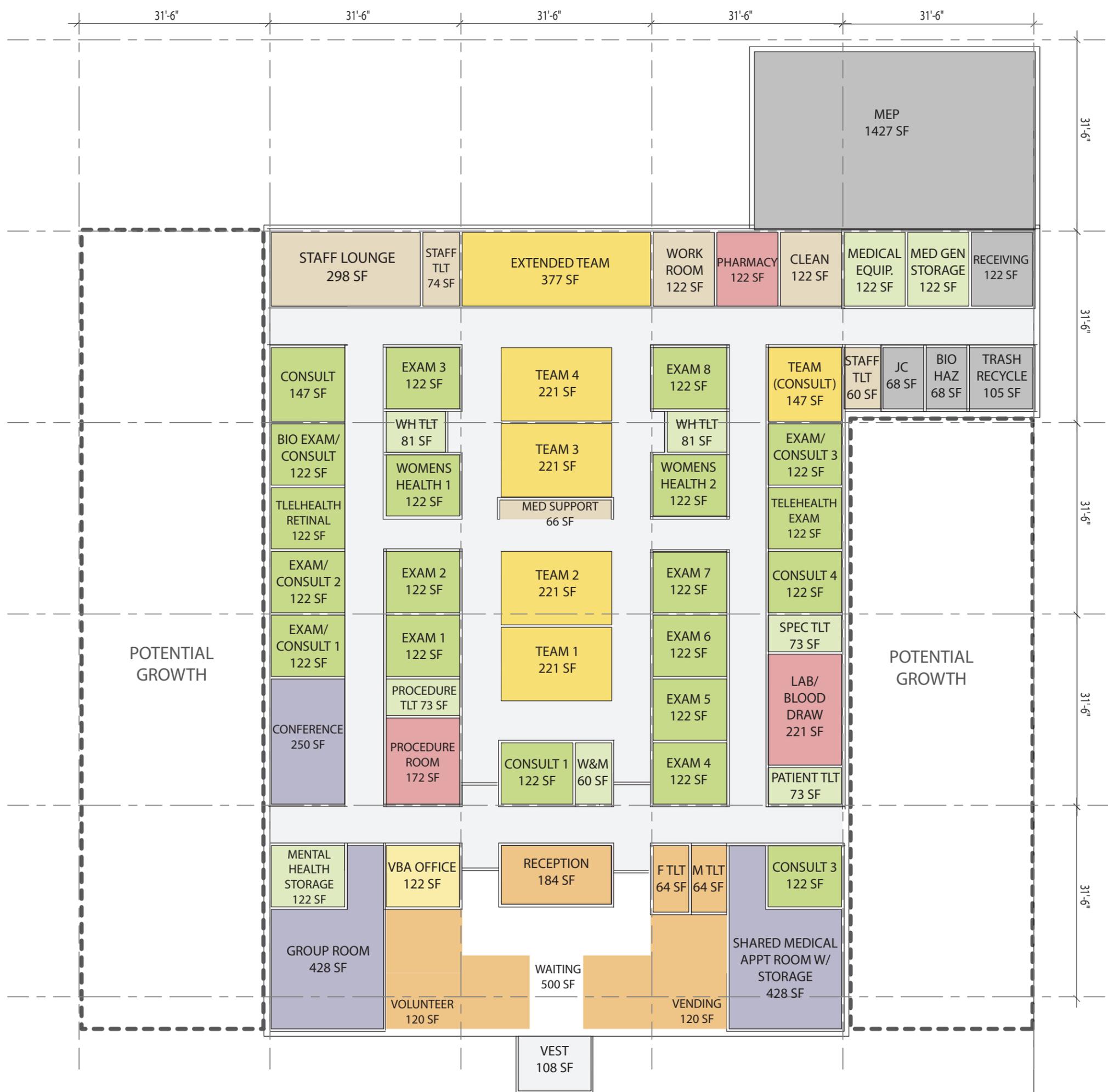
LEGEND - FUNCTION

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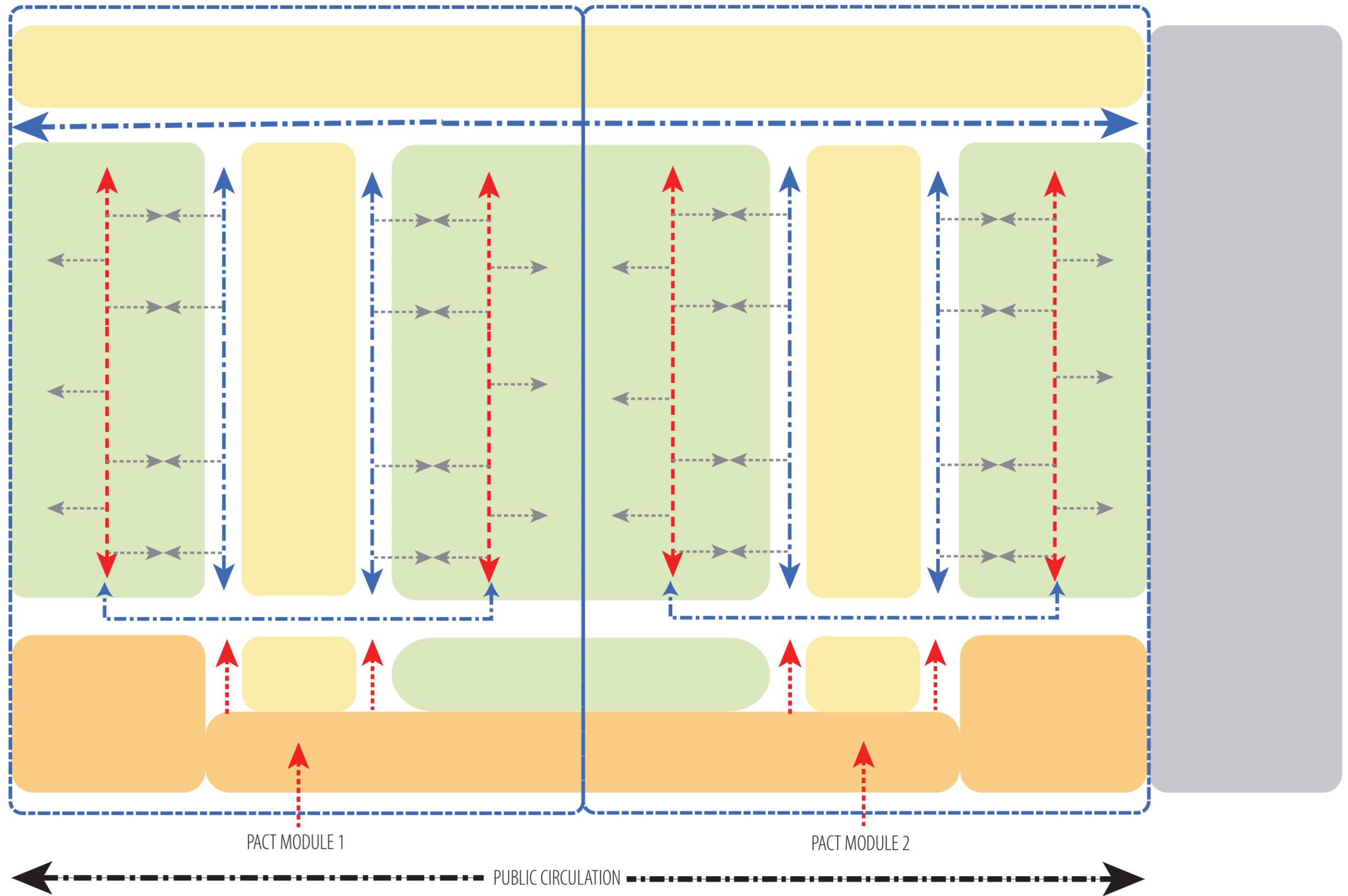
LEGEND - FUNCTION

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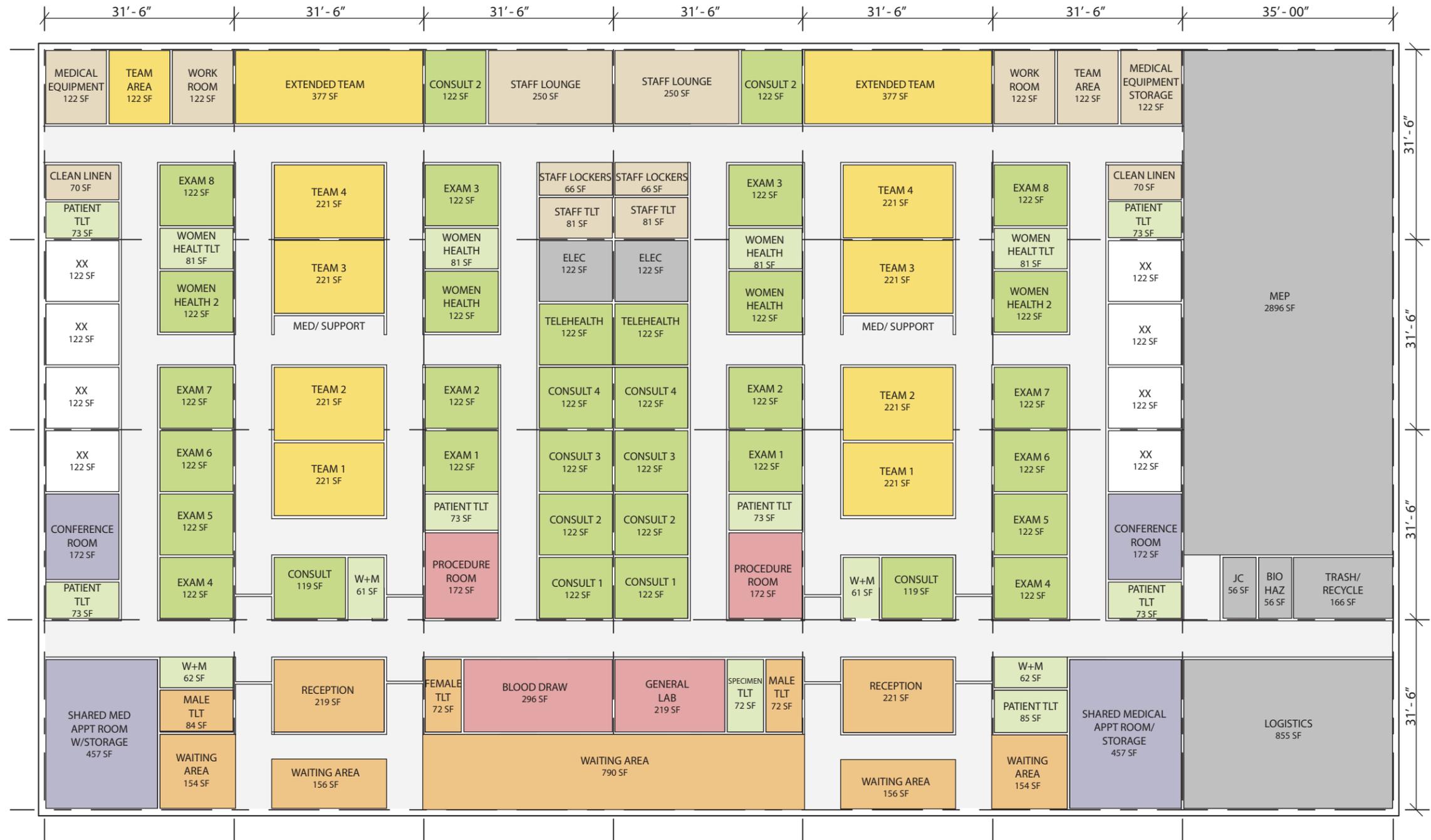
LEGEND - CIRCULATION

- ← - - - PATIENTS
- ← - - - STAFF
- ← - - - SECONDARY
- PUBLIC
- PATIENTS
- STAFF



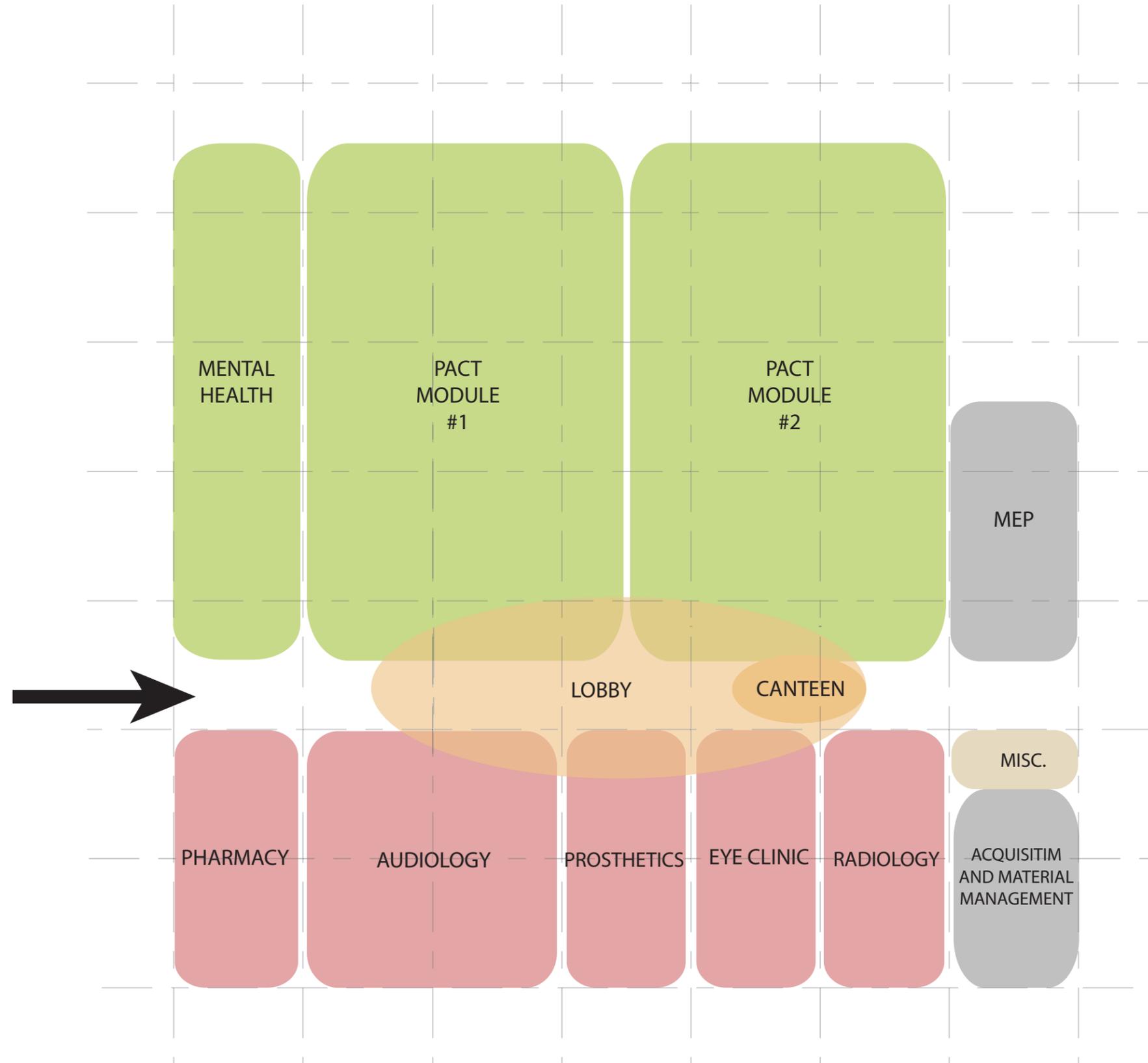
LEGEND - FUNCTION

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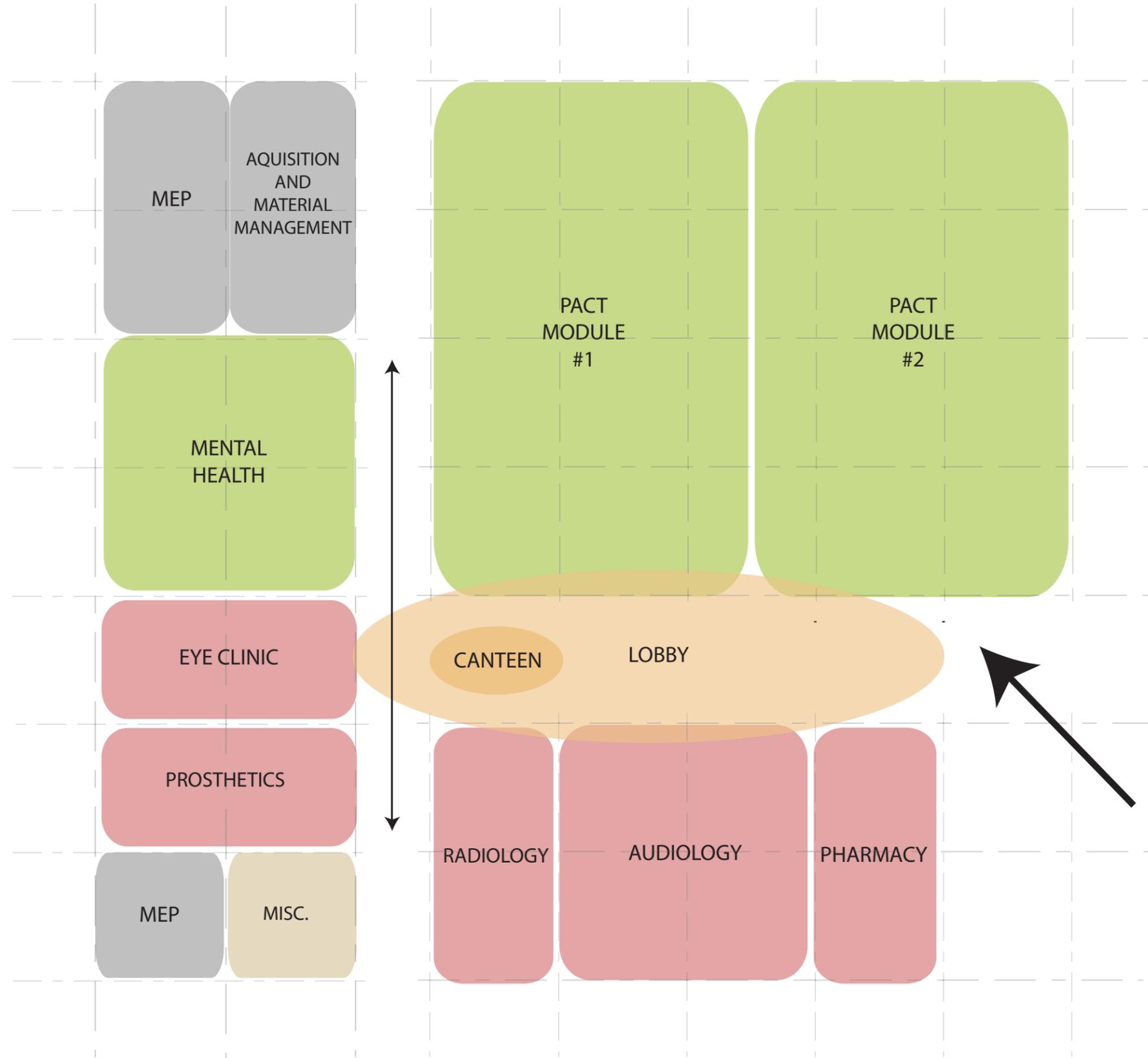
LEGEND - FUNCTION

- POD
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LEGEND - FUNCTION

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 5 December 2013
 Meeting Date 3 December 2013
 Location VA Headquarters – 810 Vermont Ave. Washington DC
 Purpose Defining Space Program – Women’s Health

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.sztuk@va.gov
Linda Chan	VACO CFM, Planner/Architect	202-632-4781	Linda.chan@va.gov
Gary Fischer	VA CFM, Senior Healthcare Architect	202-632-4898	Gary.fischer@va.gov
Dr. Angela Denietolis	James A. Haley Veteran’s Hospital, ACOS Ambulatory Care	813-972-2000 ext. 6209	Angela.denietolis@va.gov
Dr. Patricia Hayes	Director, VA Women’s Health Services	xxx-xxx-xxxx	Patricia.Hayes@va.gov
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Gabryela Passeto	SmithGroupJJR, Architect/Medical Planner	202-974-0830	gabryela.passeto@smithgroupjjr.com
Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com

ITEM	DISCUSSION	ACTION
1.0	Space Programming: Women’s Health – 1330 -1415 <i>Attendees: Jay Sztuk, Linda Chan, Dr. Denietolis, Gary Fischer, Dr. Hayes, Peggy Mikelonis, Tracy Bond, Gabryela Passeto and Chris Phillips</i>	
1.1	Jay began the discussion giving a brief project background to Dr. Hayes and Peggy Mikelonis. The team is looking to the decision makers for their guidance to make a decision about Women’s Health in PACT within the Small, Medium and Large CBOC Prototypes.	
1.2	Chris set the stage and presented the problem statement: <ul style="list-style-type: none"> During a recent CBOC template design charrette, there were concerns raised about the rooms provided for Women’s Health. A member of the steering group questioned the number of Women’s Health Exam Rooms provided. The draft PACT space planning criteria states that there should be a minimum of one Women’s Health Exam Rooms per each PACT Module; with a second one to be added if a PACT Module has more than two teamlets. The purpose of this meeting is to identify if the criteria is too robust. What is the recommendation for number of Women’s Health Exam Rooms per PACT Module(s)? 	
1.3	Dr. Hayes stressed the importance of understanding what the anticipated model of care that is going to be provided in the clinics versus what we need now. The current trend is that the population of women veterans is growing. <ul style="list-style-type: none"> Current market penetration is 17% versus 11% Women veteran’s make up 6% of patients, 15% of active duty and 18% of guards and reserves. Currently, 25% of women veterans receive care in CBOCs versus the main medical center The VA position is to place at least one designated Women’s Health Provider at each CBOC. This provider may not be fully utilized with only women’s health patients, so the provider would also be empanelled with other patients. 	

- 1.4 Dr. Hayes defined a women's health exam room as a room within the PACT module that is flexible and can be shared during non-scheduled appointments. In the primary care setting, the room needs to house the equipment and supplies necessary to perform exams without having the woman veteran leave the exam room.
- Tracy added that the one component that makes the women's exam room less flexible is that VA guidelines require a dedicated toilet unlike other DoD agencies.
- 1.5 In the small CBOC Prototype, there are 2 dedicated women's health rooms with attached toilet rooms per PACT criteria. The current layout follows a model 1 for women's health which is an integrated model. Model 2 is a women's health module adjacent to PACT and model 3 is a stand-alone women's clinic.
- The Procedure room could also be used for women's health exams and more specialized procedures.
 - Women's tele-health appointments will be held in this room since a typical women's health exam room is not large enough to accommodate the staff and patients in the same room.
 - The majority of women's health appointments are scheduled, so there are no surprises come clinic day on the availability of the flexed spaces.
 - Whether the women's health rooms are separate or integrated, there is still a need for adjoining dedicated toilet. Providing privacy and dignity for all men and women is of the utmost importance.
 - The dedicated women's health rooms can also be flexed and used for regularly scheduled appointments when not in use.
 - Ideally, the women's health rooms would be collocated, not in separate corridors as shown. As the clinics grow in the medium and large, they would optimally be clustered together to create a "mini" women's clinic. In this scenario, efficiencies of staff, supplies and materials are greatly improved.

2.0 Other Considerations:

- 2.1 Where the population supports it, women's health would be located in an adjacent corridor within PACT with a separate waiting area.
- 2.2 Adjacencies - Women's Health works closely with Mental Health and Social Work. Collocating with these services is ideal. Shared staff support services appear to be adequate and there is no need to have separate support for women's health providers.
- 2.3 Optimally, clustering women's health services in one part of the building is preferred. Sexual trauma victims will want to come thru a separate front door. Patient perception is critical. Must have clear line of sight and traffic to create a sense of privacy and security.

3.0 Discussion Outcome and Next Steps:

- 3.1 The two dedicated women's health rooms with adjacent toilets per PACT Module was deemed the most adequate solution and will remain as originally programmed.
- 3.2 An option will be presented in the upcoming charrette with a 3rd module that is mostly women's health with a sub-waiting area

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 5 December 2013
 Meeting Date 4 December 2013
 Location Conference Call
 Purpose Bi-weekly Project Update

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ITEM DISCUSSION ACTION

1.0 Project Update – 1300

Attendees: Jay Sztuk, Ding Madlansacay, Pete Yakowicz, , Caitlin Cunningham, Nancy Sussman, Linda Chan, Larry Janes, Tracy Bond, Gabryela Passeto, Chris Phillips and Emily Dickinson

- 1.1 The purpose of the call is to update attendees on the project status, address any outstanding issues/concerns, due-outs and next steps.
- 1.2 Tracy began the meeting by addressing the first agenda item. Tracy and Jay met last week and discussed the decision making process for the overall project moving forward. This discussion was a result of the multiple opinions presented during previous charrettes and meetings. It was explained to the attendees what the intent is for the remainder of the project.
 - Input and feedback is strongly encouraged by all participants, however;
 - For the VA CBOC Prototypes, the final decisions will rely on the core steering group
 - For the VISN specific projects (VISN 8, 21, and 23), the leadership will determine the final outcome.
- 1.3 Chris informed participants on the outcome of the Integrated Mental Health meeting on 21 November 2013 and the Women’s Health meeting on 3 December 2013.
 - Mental Health - 4,800 patients require a maximum of 3 mental health providers. A psychologist is already embedded are part of the BHIP program.
 - Two consult rooms would be utilized by the psychologist and social worker. The psychiatrist would have a touchdown area
 - Enlarge the ‘extended team room’ for additional visiting providers such as psychiatrist. A ‘teamlet’ for mental health is not appropriate as it is not defined the same due to the nature of the care
 - Women’s Health - The current trend is that the population of women veterans is growing.
 - The two dedicated women’s health rooms with adjacent toilets per PACT Module was deemed the most adequate solution and will remain as originally programmed.
 - An option will be presented in the upcoming charrette with a 3rd module that is mostly women’s health with a sub-waiting area

- Where the population supports it, women's health would be located in an adjacent corridor within PACT with a separate waiting area.
 - A follow-on conference call is scheduled for 6 December 2013 with Mental Health to discuss the possibility of Mental Health as a separate module.
- 1.4 Gabryela reminded attendees of the DIRT showroom tour scheduled for 1330 on 9 December 2013.
- The address is 431 Jackson Street, San Francisco, CA. 94111
 - Lewis Buchner is our DIRT Representative. His direct number is 415-672-1527
 - All charrette participants are encouraged to attend. A brief summary of the tour and photographs will be shared during the charrette for those participants whom are unable to attend.
- 1.5 Tracy outlined the structure and agenda for the upcoming charrette:
- Decision Making Process
 - Brief overview of decisions made in Charrette DC on 13-14 November 2013 and follow-on conference calls
 - Progress of Prototypical Programs for Design
 - Discuss planning guidelines
 - Patient/staff flow mapping for the three clinic sizes
 - Breakout sessions will comprise of three groups – outcome will be presented to those attending via WebEx to discuss findings
 - Module block planning
 - Breakout sessions will comprise of three groups – outcome will be presented to those attending via WebEx to discuss findings
 - PACT and Specialty Module designs and components
 - Breakout sessions will comprise of three groups – outcome will be presented to those attending via WebEx to discuss findings
 - Resolve efficiencies of spaces with Medium and Large CBOCs
 - Test-fit for the small clinic in Maui
- 1.6 Next Steps:
- The follow-on mental health meeting is scheduled for 6 December 2013 at 1600.
 - The upcoming 2-day charrette is hosted in Mare Island on 10-11 December 2013.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 16 December 2013
 Meeting Date 6 December 2013
 Location Teleconference
 Purpose Defining Space Program – General Mental Health

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ITEM DISCUSSION ACTION

1.0 Space Programming: Mental Health – 0400 - 0500

Attendees: Jay Sztuk, Linda Chan, Dr. Newcomb, Dr. Denietolis, Dr. Post, Mary Schohn, Lisa Kearney, Tracy Bond, Gabryela Passeto and Chris Phillips

1.1 The purpose of the call is to continue the Mental Health discussion that started on 21 November 2013. Jay is looking to the decision makers for their guidance to make a decision about Mental Health Integration within the Small, Medium and Large CBOC Prototypes.

1.2 Chris set the stage and presented the problem statement:

- During a recent CBOC template design charrette, there were concerns raised about the rooms provided for Mental Health. It was requested that Mental Health should follow the PACT guidelines and should therefore work out of team rooms with counseling rooms embedded throughout the primary care area. For each prototype Small, Medium, and Large: Are mental health providers only embedded within primary care or is there a more robust mental health component that would be considered separate from primary care? If the mental health providers are embedded in primary care, it was assumed that they would be housed in team rooms and provided Consult Rooms for patient encounters. If they are a separate service, it is unclear if the mental health providers would be seeing patients in a dedicated office/counseling room or if they would be housed in team rooms and be provided Consult Rooms for patient encounters. A follow-on meeting was established to talk with VA Mental Health subject matter experts.
- Current criteria for Mental Health (dated 2008) allows for an Office/Counseling Room for each Mental Health provider. Is this criteria out of touch with latest VA guidance and intent? The draft PACT space planning criteria calls for an Extended Team Room and Consult Rooms for those providers embedded with the PACT.

1.3 The outcome of the call on 21 November 2013 for Integrated Mental Health is:

- If there is a psychiatrist on the team, one of the consult rooms would become dedicated as

- an exam/office for that provider (4 consult rooms per PACT criteria)
- 1.4 The consensus was for General Mental Health to adopt the PACT model principle:
- Team rooms would be provided for General Mental Health Staff
 - Counseling spaces would also be provided that are not dedicated private offices for providers
 - In the Small CBOC, only include 1 additional mental health office and 1 group room
 - In the Medium and Large CBOCs, program remains as is for flexibility (currently 8 or 12 mental health rooms)

END OF MINUTES

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	3 January 2014
Meeting Date	10 – 11 December 2013
Location	VISN 21 Headquarters Conference Room/ VA Outpatient Clinic Mare Island
Purpose	Design Charette Mare Island

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ITEM	DISCUSSION	ACTION
	Day 1 - 10 December 2013	
1.0	Charrette - Mare Island	
	<i>Attendees: Refer to list on previous page</i>	
1.1	Introductions were made around the table.	
	Tracy Bond explained the structure of the next two days.	
	<ul style="list-style-type: none"> There will be points in the charrette where attendees will break into smaller groups for working sessions. Phone attendees can join a group, or log off and call back in during the recap. 	
1.2	Tracy discussed the decision-making process.	
	<ul style="list-style-type: none"> The CBOC steering group is the final decision-maker in the prototype designs. Each VISN will have final say over their CBOC clinic test fit. Jay Sztuk emphasized that there are three VISNs involved for representation and buy-in. The steering committee provides decision-makers within the wider representation. 	
1.3	Why prototypes? Tracy explained there is a need for incremental growth strategy, but growth with minimal disruption to care.	
2.0	Tracy, Gabryela Passeto and Chris Phillips updated the team on side discussions/meetings that have occurred.	
2.1	Tele-medicine can be supported with CAT6 infrastructure.	
	<ul style="list-style-type: none"> All rooms should have this infrastructure. There are to be two dedicated tele-medicine rooms per module. 	
2.2	Additional administrative offices have been added to the Programs for Design (PFDs).	
	<ul style="list-style-type: none"> They are flexible per VISN/site. The location of offices within the clinic will depend on the occupant. If standardizing, could place two at front of the clinic and one toward the rear. 	
2.3	Patient care spaces should be universal rooms at 125 SF (exam, consult, dental, etc).	
	<ul style="list-style-type: none"> This applies to rooms that can be exam in future. Team does not want to artificially change the criteria when unnecessary. 	
2.4	Point of Care Testing (POCT) at the last charrette included one phlebotomy in the POCT room.	
	<ul style="list-style-type: none"> PACT guidelines lean toward blood draw in room, but some patients come to the clinic solely to have blood drawn. POCT is in prototypes, but is not mandatory in actual clinic designs. POCT is included in small and medium, large has a lab. 	
2.5	Women's Health criteria is not changing.	
	<ul style="list-style-type: none"> Each PACT module (4 teamlets) will include 10 exam (8 universal exam and 2 women's exam with dedicated toilet) and one procedure room with toilet. It will be a location-specific decision whether to cluster Women's Health in medium and large clinics. There is a balance between giving an identity and flexibility. For instance, Tampa's women's population is under 400, so they would prefer not to dedicate a hallway for a designated clinic. The women's exam rooms do not have to be dedicated in practice. However, the adjacent toilets are not flexible space. The majority preference is to leave Women's Health exam rooms embedded within the PACT. 	
2.6	Mental Health has an integrated component within PACT.	
	<ul style="list-style-type: none"> Potentially three staff are embedded: social work, psychiatrist and psychologist. There are five extended team slots in PACT. These are not named providers, but location-specific. The Mental Health professionals are included in this five. If there is a robust, specialized Mental Health clinic, staff will be in team room but will also 	

require one-to-one ratio private consult rooms.

- 2.7 Pharmacy at the small clinic level is an Automated Dispensing System (ADDs).
- 2.8 Wireless is necessary everywhere in the CBOC. There should be one network for facility and one for patients and family.

3.0 Planning Guidelines

Tracy explained the planning guidelines that are informing the prototype designs:

- Prototypes are designed to support an evolving clinical model of care and accommodate continuous change in the ongoing drive towards optimal value
 - Modular planning with flexible backbone supporting a universal space field.
 - Populated with a Kit of Parts – based on best clinical practice and coupled with a system of continuous measurement to evaluate effectiveness and improved patient outcome.
 - Creation of building standards and guidelines that are based on best clinical outcome and operational effectiveness including safety, efficiency and a patient/family centered model of care
 - Incremental Growth strategy
 - Flexibility – to create a facility design that easily and nimbly adjusts to changes in demand while minimizing disruption to operations, and construction costs.
- 3.1 Waiting area is a balance between multi-disciplinary spaces and patient privacy.
 - Opportunities for private conversations need to be created at check-in.
 - The Lobby program area does not include Waiting. Waiting square footage is included under PACT.
 - The waiting area will have different functions pending location and clinic size.
 - Patients also look to this area as more than just waiting. Dr. Denietolis suggested there should be fewer seats available, but have more functions for the veterans.
 - 3.2 Exam rooms will be universal.
 - All will be 125 SF with sinks.
 - All will be tele-health enabled.
 - Women's Health and Procedure will have adjacent toilets.
 - Weights and Measures can be in room or in an alcove. A roll-on scale is beneficial, especially for patient populations like Hawaii. The prototypes will show alcoves.
 - 3.3 Consult rooms are at 125 SF and flexible space.
 - 3.4 Soiled rooms are not always necessary. Most sites are using disposables and a single hamper is sufficient for linens.
 - Most clinics are using disposable gowns and tools
 - Room will be necessary if handling urology or cysto.
 - 3.5 Support spaces can and should be shared (janitor closets, lounges, storage, quiet team work areas).
 - If a module is duplicated, the support space may not be duplicated.
 - There is no lactation room for staff currently in the PACT criteria. A bathroom is not appropriate. An available consult or exam room could be utilized.

4.0 Breakout Session #1 – Patient and Staff Flow

- 4.1 The group broke into three smaller work groups to map patient and staff flow that represented a small, medium and large clinic.
 - The goal is to first map current patient flow through a clinic. Then the same exercise should be followed in the ideal situation, in a PACT model.
 - This will inform adjacencies and circulation.
 - How does this differ from the ideal patient flow?
- 4.2 The group reconvened to discuss findings:
Small CBOC:
 - Existing Flow – 2 scenarios: a patient arrives at the clinic with a scheduled appointment or the patient is pending transportation, walk-in, registration for eligibility or homeless seeking

shelter

- Many steps for patient to take and ping pong to where they finally need to go
 - Patients fill out the “yellow paper” to be prioritized, not triaged
 - Optimal scenario is cleaner with significantly less movement from the patient
 - Dr. Denietolis added staff should be utilized to their highest degree level and not just pass off a task to someone else –
 - A LPN or RN can do vitals for the patient
 - If a patient’s needs can be met, they can exit the clinic or wait to see provider for further examination
 - All services should be brought to the patient
- Medium and Large CBOCs:
- Existing Flow – Patient triggers encounter, arrives at very busy reception, awaits further direction, lots of back and forth between staff and spaces.
 - Optimal –
 - Pre-visit call becomes critical for this process
 - Patient arrives at kiosk located in the main lobby, prints out their schedule for their visits throughout the clinic – this cuts down on the face to face encounter
 - Patients visit other specialties prior to seeing their primary care provider and can have a better comprehensive exam with all test results – this maximizes the patient and providers time during the encounter

4.3 Specialty Clinics:

- No vitals pre-check or patient education at the end of the encounter
- Very different model than primary care
- Specialty clinic should flow and function more like PACT instead of individual departments
 - Resources prohibit this currently, but VA is moving towards this model of care
- More waiting area is required in a specialty clinic
- For every patient a primary care provider sees, a specialist sees at least 2

5.0 Breakout Session #2 – Block Planning

- 5.1 The group broke into three smaller working groups to block and stack a small, medium and large clinic. The purpose of the exercise is to identify optimal departmental adjacencies and continue to build on the patient flow exercise from earlier in the day to verify assumptions.

Day 2 - 11 December 2013

- 5.2 The design team began with discussions and graphics to support the outcome of the breakout session from the previous day.

5.3 Key Take Away from Day 1: Small CBOC

- Changing the lobby perception for patients to foster a welcoming and healing environment:
The Commons
 - Larry Janes stated he is concerned about the lobby perception overall.
 - John Caye added that in urban settings, this model does not work because security does not support it. He recommends this become a social mission for canteen services. Sylvia Wallace stated this is a basic concept for canteen services which is to provide an “oasis” for the veterans and is a main part of their function
 - C.B. Alexander added this is a universal issue, veterans come and hang out with each other in clinics
 - Gary Fischer added this is an issue that has never been paid attention to. What actually defines or encompasses a lobby? Nowadays, most lobbies are cramped and actually deter the increasing number of PTSD patients. Criteria has a “postage stamp” footprint of what a lobby traditionally meant that is not in line with today’s modern interpretation

- Consider ways to create and foster structural socialization for veterans
- Protecting patient privacy during check-in encounter
- Mobile tech pad for ultimate flexibility of services not provided within the clinic

Medium CBOC:

- Consider auditory separation per discipline, ie. audiology away from mental health
- Mobile tech pad for ultimate flexibility of services not provided within the clinic
- Canteen near lab for fasting patients
- Radiology located along an exterior wall for maximum flexibility

Large CBOC:

- Provide more waiting areas within the specialty clinic modules versus PACT module
- One story building seems to exceed patient travel distance; two story building causes disorientation with vertical circulation

5.4 Several blocking diagrams were presented from each breakout session:

Small CBOC:

- Reception and Kiosks were placed in separate ends of the waiting area for auditory privacy
- Phlebotomy was placed off reception for patients going solely for blood draw or specimen collection
- Security should be provided in an as needed basis for clinics
 - John Caye added it is preferable for the veterans to see a security presence in the clinics. This also helps to deter unwelcome behavior in the clinics

Medium CBOC:

- Clinic Management does not need to be in the front of the clinic. Can move to rear with the exception of HAS. Flex office are better located in their place
- Service organization offices such as patient advocated should be located in the lobby areas where more accessible to patients
- Comp & Pen exams can be done on the weekends since rooms are universal, best located adjacent to Audiology
- Segregate Primary Care and Specialty care, but have them share the same front door for patients

Large CBOC:

- A single story large clinic becomes very long and dense
- Scale of the large clinic adds a significant increase in walking distance for patients. This is especially problematic for elderly veterans
- Priority for departments located along the exterior: Mental Health to have windows and egress access, Radiology, Acquisitions and Materials Management for loading dock entrances
- Three typologies were graphically shown: Linear, L-shape and U-shape

6.0 **Structural Grid Implications**

6.1 Tracy explained the exercise that was done to determine the proper structural bay based on the 125 SF universal room size.

- 31'-6" x 31'-6" = 122 SF
- 32'-0" x 32'-0" = 127 SF
- 31'-9" x 31'-9" = 124 SF
- 31'-10" x 31'-10" = 125 SF
- John Caye appreciates the exercise of seeing these options because 1 SF costs the VA approximately \$1,000.
- Gary emphasized the goal is to be within 10% range; 31' to 32' grid
 - Will show optimum, but understand it's not always going to be achievable because of columns in exam rooms, etc.
- Jay added there is a limit when considering prefabricated systems. The maximum width for structural beams is 16'. As a result, structural grids cannot be larger than 32'.

- Dr. Newcomb prefer an irregular grid of +/- 30' to 20' for the staff core
 - Tracy explained there are benefits to a regular grid as it allows for infilling team space for clinic renovations to exam rooms if needed.
 - She is hesitant to show an undesirable end state with such a tight teaming space
- Sharon Espina asked what seismic implications this has for regions such as the Pacific Islands.
 - Tracy explained seismic reinforcement is typically addressed with cross bracing
- Tim Bertucco added an option should be considered with irregular grids since most spaces are leased as is and grids are not as generous as proposed options
 - Currently have to stick to a 10,000 NUSF threshold
 - In some cases, tenants will have to be in open offices, with a single loaded corridor for exam/consult spaces
 - This implications suggests a deeper look into the departmental grossing factor for PACT

7.0 Breakout Session #3 – Develop Module Design and Components

7.1 Modularity lends itself to quality control, begins to standardize room design and operations, and creates efficiencies during construction and owner occupancy. The modularity of the program and standardization of the components are critical to the success of the planning effort.

- Populated with a kit-of-parts
- Incremental growth strategy
- Scalability
- Flexibility
- Identity - VA Branding
- Site adaptable

7.2 The group broke into three smaller working groups:

- Group 1 focused on the CBOC Modular Planning and looked at layouts for the One, Two and Three PACT Modules.
- Group 2 focused on the specialty clinic layouts for Audiology, Eye Clinic, Mental Health, Multi-specialty clinic, Dental
- Group 2 focused on the specialty clinic layouts for Pharmacy, Pathology + Laboratory Medicine, Radiology, Physical Medicine and Rehabilitation, Prosthetics + Sensory Aids, Home Based Primary Care

7.3 The group reconvened to discuss findings:

- Group 1:
 - 2 Tele-health, 1 Tele-retinal
 - Police and Security located near Reception
 - Pharmacy pulled near the staff team areas adjacent to the work room
 - 1 large lab with 2 phlebotomy stations and adjacent specimen toilet and patient toilet with specimen pass thru
- Women's Health has a dedicated corridor in the medium and large prototypes
- Procedure rooms kept towards the rear of clinic
- Groups 2+3:
 - Combining specialty modules into a specialty module like PACT with shared teaming spaces
 - Radiology is difficult to resolve since so many factors are site specific
 - Follow on discussions with specialty care representatives are required for final input
 - Add employee wellness module with PM+R if possible

8.0 Maui Test Fit

8.1 Chris Phillips began the discussion reviewing the PFD provided for the Maui Test-Fit.

- The following changes were made:
 - Resize universal rooms to 125 sf

- Increase the number of teamlets from 3 to 4 where the fourth teamlet is for specialty
 - Add a third Tele-Health Room and size them at 125 sf
 - Eye Lane will be a folded eye lane at 125sf rather than 200 sf
 - Resize Toilet Rooms to appropriate single toilet sizes
- 8.2 Brenna made live changes to the floor plans for the Maui clinic using the small prototype layout that was developed during the charrette.

9.0 Wrap Up + Next Steps

- 9.1 Bill Kline thanked all attendees for their time and participation over the last couple of days.
- 9.2 Meetings will be set-up to discuss other specialties between now and the next charrette
- 9.3 Jay recommended the next charrette be held over 3, 6 hour days to allow the design team more time to implement discussion outcomes and keep participants from getting burned out.
- 9.4 John Caye recommends looking into the departmental gross and overall building grossing factor. A lot of spaces look overly efficient.
- 9.5 A follow-up discussion will be had to finalize the test fit for Maui and will be presented back to attendees at the next charrette
- 9.6 Charrette Tampa will be hosted by VISN 8 on 14-16 January 2014

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 3 January 2014
 Meeting Date 17 December 2013
 Location 90 K St. NE, Washington DC 7th Floor
 Purpose Defining Space Program – Dental Services

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Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com

ITEM	DISCUSSION	ACTION
1.0	Space Programming: Dental Services – 1130 -1300 <i>Attendees: Jay Sztuk, Dr. Bestgen, Dr. Arola, Dr. Colon, Dr. O'Toole, Gregory Smith, Tracy Bond, Gabryela Passeto and Chris Phillips</i>	
1.1	Dr. Bestgen began the discussion giving a brief project background to Dr. Arola, Dr. Colon and Dr. O'Toole. The team is looking to the decision makers for their guidance to make a decision about Dental Services within the Small, Medium and Large CBOC Prototypes.	
1.2	Chris set the stage and presented the problem statement: <ul style="list-style-type: none"> During the 13-14 December 2013 charrette in Mare Island, breakout sessions were had to discuss the layout of the specialty clinics and how they would be modules that could be added to any clinic should the workload justify a need in the geographical area. During the breakout session, the layout of the dental module was reviewed and questions came up about why the modules were not designed similar to the PACT module. Dr. Bestgen suggested a meeting to discuss these options further and include other decision makers. The purpose of this meeting is to identify what the optimal layout of the dental clinic module should be and to review the assumptions used in the prototype study to date 	
1.3	Dr. Bestgen addressed some issues/concerns regarding the inclusion of dental services in clinics: <ul style="list-style-type: none"> Issue is the concern with limited efficiencies when there is less than 2 dentists in any one CBOC Fewer than 5 DTRs to start off with is not optimal. Helps to recognize what staffing is available overall with allocation methods, then it is up to the facility to determine this Dental modules stay only in Large CBOCs typically. It is a rare instance where a Medium CBOC would have this module. 	
1.4	Chris outlined the current dental assumptions: <ul style="list-style-type: none"> 2 Dentists 	

- 2 Hygienists
- 6 Multi-Functional Operatories (2 per dentist; 1 per hygienist)
- 1 X-Ray Area for Pano
- Off-Site sterilization

2.0 Discussion Outcome and Next Steps:

- 2.1 Dental will only be programmed in the Large Prototype. The Dental service representatives from headquarters feel it is not worthwhile to staff a facility with less than 2 dentists because it is very inefficient. The following decisions were also made:
- No dedicated chief office required
 - Add a team area for multiple staff with a team workroom/consult space
 - Enclosing the DTRs is optimal, not open due to patient privacy and noise
 - Cone beam in the x-ray room with pano is not to be included.
 - The intraoral tube heads are located in each DTR, not shared.
 - Tele-health: collocated to PACT so that they can use it or even the specialty clinic
 - Tele-dentistry requirement is similar to what tele-derm requires that is included in the specialty clinic
 - Size of clean and soil for dental needs to grow and be included since they don't have a central sterile in CBOCs, typically. Typically 60-80 SF, currently programmed 100 SF
 - Sharing support spaces with other specialty groups such as lounges and lockers, etc...

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 4 January 2014
 Meeting Date 19 December 2013
 Location Conference Call
 Purpose Bi-weekly Project Update

PARTICIPANT	COMPANY	PHONE	EMAIL
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ITEM DISCUSSION ACTION

1.0 Project Update – 1400

Attendees: Jay Sztuk, Ding Madlansacay, Pete Yakowicz, Linda Chen, Larry Janes, Tracy Bond, Gabryela Passeto, Chris Phillips and Ashley Andersen

- 1.1 The purpose of the call is to update attendees on the project status, address any outstanding issues/concerns, due-outs and next steps.
- 1.2 Chris informed participants on the outcome of the Dental meeting on 17 December 2013:
 - Dental will only be programmed in the Large Prototype. The Dental service representatives from headquarters feel it is not worthwhile to staff a facility with less than 2 dentists because it is very inefficient
 - No dedicated chief office required
 - Add a team area for multiple staff with a team workroom/consult space
 - Enclosing the DTRs is optimal, not open due to patient privacy and noise
 - Cone beam in the x-ray room with pano is not to be included.
 - The intraoral tube heads are located in each DTR, not shared.
 - Tele-health: collocated to PACT so that they can use it or even the specialty clinic
 - Tele-dentistry requirement is similar to what tele-derm requires that is included in the specialty clinic
 - Size of clean and soil for dental needs to grow and be included since they don't have a central sterile in CBOCs, typically. Typically 60-80 SF, currently programmed 100 SF
 - Sharing support spaces with other specialty groups such as lounges and lockers, etc...
- 1.3 Tracy discussed the logistics for the upcoming charrette in Tampa currently scheduled for 14-15 January 2014:
 - Charrette location was reserved by Dr. Denietolis:
 - University of Phoenix Conference Center
12802 Tampa Oaks Blvd.
Temple Terrace, FL. 33637
 - Jay proposed a 3-day charrette with shorter days, 6 hours each as a result from lessons learned from the Mare Island charrette in order to accomplish more without burning out each

day. This also gives the design team time between sessions to compile input from the previous day and make it easier on those who are dialing in remotely.

- We will start on Tuesday 14 January at 8:30 AM and run till approximately 3:30 PM
- On Wednesday morning we will tour the new Primary Care Annex from 8:00 AM to 9:30PM; the charrette will begin at 10:00 AM
- Thursday will begin at 10:00 AM and finish at approximately 4:30 PM.
- A formal agenda for the charrette will be distributed prior to the bi-weekly call on 7 January 2014
- Hotel recommendations are Embassy Suites, Hilton Garden Inn Tampa North (walking distance to conference site) and Hampton Inn & Suites Tampa North
- Gabryela will follow-up with Dr. Denietolis to confirm what IT capabilities will be available to the design team for their use. Findings will be discussed on the 7 January 2014 bi-weekly call

1.4 Next Steps:

- Bi-weekly call scheduled for 31 December 2014 is rescheduled for 7 January 2014 due to the holidays
- The upcoming 3-day charrette is hosted in Tampa on 14-16 January 2014.
- Jay will be scheduling program meetings with specialties services for Radiology, Audiology, Optometry

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 6 January 2014
 Meeting Date 6 January 2014
 Location 425 I Street, NW, 6th Floor, Room 6W305
 Purpose Defining Space Program – Radiology

PARTICIPANT	COMPANY	PHONE	EMAIL
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ITEM	DISCUSSION	ACTION
1.0	<p>Space Programming: Dental Services – 1130 -1300</p> <p><i>Attendees: Jay Sztuk, Linda Chan, Gary Fischer, Dana Sullivan, Dr. Charles Anderson, Tracy Bond, Gabryela Passeto and Chris Phillips</i></p>	
1.1	Jay began the discussion giving a brief project background to Dana Sullivan and Dr. Anderson. The team is looking to the decision makers for their guidance to make a decision about the programmatic requirements for Radiology within the Medium and Large CBOC Prototypes being developed. Jay explained the idea is to standardize a core component to reduce the amount of ground work that must be done when starting the design of a new CBOC.	
1.2	<p>Chris set the stage and presented the assumptions that support the spaces included in the Prototype PFD:</p> <ul style="list-style-type: none"> • Currently programming Radiology only in the Medium and Large Prototypes • The purpose of this meeting is to identify when and if Mammography, Ultrasound and Bone Density services should also be provided in the Large Clinic Prototype • Medium CBOC: <ul style="list-style-type: none"> ○ 2 Dressing Rooms ○ 1 Film Processing Room ○ 1 General Purpose Radiology Room ○ 1 Office, Staff Radiologist/Tech ○ Waiting Area • Large CBOC: <ul style="list-style-type: none"> ○ 1 Diagnostic Bone Densitometer ○ 3 Dressing Rooms ○ 1 Film Processing Room ○ 1 General Purpose Radiology Room ○ 1 Mammography Room ○ 1 Office, Staff Radiologist ○ 1 Radiographic / Fluoroscopic Room ○ 1 Shared Office, Tech ○ 1 Ultrasound Room ○ 1 Ultrasound Toilet 	

- A concrete pad and utility hookups will be provided adjacent to the Large CBOC to allow for MRI or CT units in the future.
- 1.3 Dr. Anderson addressed some issues/concerns regarding the inclusion of radiology in clinics:
- The guiding factor is based on the type of clinic versus what the size of the clinic is. It is not appropriate to tell the VA Medical Center what they need to have. The decision on what type of radiology service that is provided in CBOCs comes from the medical center.
 - The question should be if they have radiology service, what does it look like versus this is what they need to have
 - Chris asked if there are better numbers to look at to establish thresholds that support the inclusion of certain modalities such as mammography, ultrasound and bone density.
 - Dr. Anderson stated that in his experience, medical centers tried to include radiology in all clinics
 - Gary Fischer added the assumptions Chris Phillips outlined are place holders as radiology service is dependent on how the medical centers provide this service by location
 - A radiologist is needed if doing fluoroscopies or ultrasounds, but definitely not needed in clinics if are only producing plain films.
 - Dr. Anderson believes it is arbitrary to answer whether mammography should be included in a large clinic. His proposal is as follows for 3 distinct modalities:
 - Radiology only service, multi-purpose, general diagnostic room in every CBOC
 - Radiology service plus Fluoroscopy and Ultrasound
 - Radiology service with Fluoroscopy and Ultrasound, plus Mammography and Bone Density
 - Gary Fischer suggests for the purpose of this discussion, provide a typical Large A and Large B where Mammography and Bone Density are alternatives to be added.
- 1.4 Dana Sullivan added these decisions require further assessment
- Moving forward, with an increasing number of women's veterans, the assumption is additional mammography programs will be established within CBOCs
 - Some of these additional modalities are also dependent on the availability of specialty radiologists in the area
 - Mammography is federally governed; therefore, there must be a certain number of female patients before it can be provided. Further, if it is provided it does not mean the women veterans will come to the clinic for the service when they have an already established relationship with another facility for this service.
- 1.5 Tracy Bond reviews the preliminary layouts developed based on the spaces in the Program for Design:
- The Medium CBOC module includes one general radiology room with supporting space. Per the discussions the following changes will be addressed in the revised layout.
 - The small sub-waiting area is not necessary for the general radiology room because patients can wait in the main waiting area until they are called back to a dressing room. They wait in the dressing room and will go directly into the rad room.
 - Two dressing rooms are necessary and should be placed so the patient does not need to travel up a hallway.
 - The Film-Processing Room will be re-labeled to Multipurpose/Viewing.
 - The Large CBOC modules grows from the one general radiology room per the program. Per the discussions the following changes will be addressed in the revised layout.
 - The small sub-waiting area is not necessary for the general radiology and rad/flouro rooms because patients can wait in the main waiting area until they are called back to a dressing room. Each room should have two dressing rooms.
 - The dressing rooms should be placed so the patient does not need to travel up a hallway.
 - A patient toilet is should be included to support this area.
 - The Film-Processing Room will be re-labeled to Multipurpose/Viewing.

- Ultrasound will have an adjacent toilet as shown.
 - Space for wheelchairs, stretchers, etc. is not necessary outside the rad rooms. These will be parked within the room.
 - For the alternate including Mammography and Bone Density a small female sub-waiting with dressing room will be included. These spaces should be located near ultrasound.
 - Mammography should increase from 160 sf to 180 sf to ensure enough clearance for patients with limited mobility.
- 1.6 Other considerations:
- Gary questioned if general radiology rooms required different equipment for bariatric patients
 - Dana Sullivan answered all general radiology tables are weighted to support bariatric patients
 - Jay asked if it makes sense to decrease the size of the waiting areas
 - Dr. Anderson said it is still very common for patients to arrive with a family member to appointments and need a place to wait. Eliminating or decreasing the waiting room size is not appropriate.

2.0 Discussion Outcome and Next Steps:

- 2.1 Radiology will only be programmed in the Medium and Large Prototypes. It will be decided by the local medical centers what type of service will be included in the CBOCs. The following decisions were also made:
- Mammography Room will change from 160 sf to 180 sf per latest update to Women's Health criteria
 - Bone Density Room sizing changed from 120 sf to 180 sf per latest update to Women's Health criteria. This room will be increased to 125 sf.
 - Gary Fischer suggests making this 125 sf in order to flex as a universal room
 - Dana Sullivan agrees that 180 sf is too large and that 125 sf is more than adequate for this room type
 - The design team will use 125 sf for the Bone Density Room.
 - In the Large Clinic, provide 2 dressing rooms for general radiology and 2 dressing rooms for radiographic/ fluoroscopic room
 - We will look at increasing the number of toilets and their proximity to the R/F Room and Mammography Room in the Large CBOC Prototype.
 - A small women's sub-waiting will be added when Mammography and Bone Density are included in the Large CBOC.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 29 January 2014
 Meeting Date 7 January 2014
 Location Conference Call
 Purpose Bi-weekly Project Update

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ITEM DISCUSSION ACTION

1.0 Project Update – 1400

Attendees: Jay Sztuk, Ding Madlansacay, Pete Yakowicz, Linda Chan, Alejandra De La Torre, Nancy Sussman, Dr. Denietolis, Larry Janes, Tim Bertuccio, Tracy Bond, Gabryela Passeto, Chris Phillips, Ashley Andersen and Bill Hoffman

- 1.1 The purpose of the call is to update attendees on the project status, address any outstanding issues/concerns, due-outs and next steps.
- 1.2 Chris informed participants on the outcome of the Radiology meeting on 6 January 2014:
 - Radiology will only be programmed in the Medium and Large Prototypes. It will be decided by the local medical centers what type of service will be included in the CBOCs. The following decisions were also made:
 - Mammography Room will change from 160 sf to 180 sf per latest update to Women's Health criteria
 - Bone Density Room sizing changed from 120 sf to 180 sf per latest update to Women's Health criteria. This room will be increased to 125 sf.
 - In the Large Clinic, provide 2 dressing rooms for general radiology and 2 dressing rooms for radiographic/ fluoroscopic room
 - We will look at increasing the number of toilets and their proximity to the R/F Room and Mammography Room in the Large CBOC Prototype
 - A small women's sub-waiting will be added when Mammography and Bone Density are included in the Large CBOC
- 1.3 Tracy outlined the proposed agenda for the upcoming 3-day charrette in Tampa 14-16 January 2014:

- Day 1
 - Finalizing small clinic prototype and Maui test-fit
 - Discussions and Key take away from Charrette Mare Island including, block and stack options, clinic flow, growth between Medium and Large Prototypes and patient flow diagram overlays
 - Specialty modules including department updates and program changes, development of specialty modules, growth of modules and impact of specialty modules on block and stack options
 - Day 2
 - Primary Care Annex Tour
 - Present floor plans for the medium clinic breakout session. Discussions will focus on pros/cons of clinic layout, review PFD and identify spaces of opportunity or sharing, optimize layouts for future flexibility
 - Discussion of specific room and equipment layouts as presented in small clinic prototype and compare current guidelines vs. PACT layout
 - Equipment requirements
 - Day 3
 - Review of Medium prototype selected from previous day, compare prototype PFD to Tampa Test-fit PFD – identify areas that are common vs. unique
 - Group working session to test-fit the Tampa clinic: customization of medium prototype, modify and develop floor plan, adjacencies and special equipment
 - Resolution on Tampa test-fit
 - Jay expressed some concerns about the proposed agenda:
 - He feels more than an hour is needed to finalize the small prototype
 - Need to provide pros and cons about the bay size prior to finalizing any prototypes
 - Dr. Denietolis has invited specialists to come to the charrette on day one in the 1045-1200 time slot. Audiology, Physical Therapy and Pharmacy will attend. Mental health and Radiology may pop in for a more focused discussion on the Brooksville clinic test fit on the third day.
 - Dr. Denietolis reminded the team that audio conferencing is not available in the reserved space. The room does not have a phone
 - Jay suggested we can try to use the audio connection through the computer on the Lync web meeting for those calling in.
 - Nancy Sussman added it is very difficult to follow along on the phone and feels the computer audio will make it even more difficult.
 - Dr. Denietolis will request a phone for the room, but we should not count on it
- 1.4 Tracy discussed the February 2014 logistics in Minneapolis:
- Contractually the charrette was scheduled for two full working days for 11-12 February 2014
 - Jay wants to make sure we are not selling ourselves short and wants to allow more time. He anticipates there will be a lot of loose ends to resolve and does not want to constrain the group to only two days
 - Dr. Denietolis suggests to have at least an additional half day
 - Jay stated it is not unrealistic to spend most of day 1 reviewing the Progress submittal as it will have significantly more content and be highly developed

2.0 Next Steps:

- The upcoming 3-day charrette is hosted in Minneapolis on 11-13 February 2014.

END OF MINUTES

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 21 January 2014
 Meeting Date 8 January 2014
 Location Teleconference
 Purpose Discuss Maui Test-Fit Layout

PARTICIPANT	COMPANY	PHONE	EMAIL
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ITEM DISCUSSION ACTION

08 January 2014

Maui Test-Fit call

Attendees: Refer to list above

- 1.0 Chris Phillips goes over some outstanding questions about the Maui Clinic layout.
 - In the Small Prototype, several spaces have been labeled as flex offices and to accommodate program variation for specific clinic locations. When the MAUI program is plugged in, should those rooms be assigned per the program or left as "flex"?
 - Should security and police be included in Maui's official program since a police space is designated in the small prototype?
- 1.1 Maui participants say that the program and the plan should show the same spaces.
 - Are there more restrooms shown that are called for in the program?
 - Chris Phillips says the Maui test fit is comprised of the small prototype but has been modified and added to in order to accommodate Maui's specific needs so the plan will eventually correspond to the Maui program but may differ from the prototype.
- 1.2 Discussion of Flex spaces
 - Maui participants say that their home-based primary care personnel would likely utilize some of the flex space
 - Because home based primary care providers aren't always in the clinic, their work spaces and conference spaces can be shared space
- 1.3 Maui Group discusses cost concerns
 - The total project cost may not exceed \$10 million, this number reflects the total cost and not only the construction cost.
 - It is difficult to estimate costs because the cost of the land lease is still unknown
 - \$8 million construction cost would come close to the \$10 million total cost
 - Could a section of the building be removed if needed to reduce costs?

- 1.4 Craig Oswald agrees that the test fit for Maui should correspond with the Maui program that includes three teamlets plus one specialty care teamlet
- Dr. Angela Denietolis points out that the number of PACT modules is the same for Maui and the small prototype, but this program has four total teamlets
 - The reception is 360 SF per the criteria, but is increased because there are four teamlets
 - Waiting square footage includes kiosks, patient education, family waiting
- 1.5 Group discussion of PACT Staff Admin changes
- Team room area increase
 - Telehealth increased to 125 SF to adhere to typical room size
 - Team area in the center can accommodate more team members in addition to the basic PACT teamlets
 - Chris Phillips emphasizes that the goal is to make the program and the plan consistent
- 1.6 Mental Health Team Discussion
- Room counts are the same except there are two group rooms instead of three
 - Group discusses whether mental health should be treated the same as primary care and determines that there will be some differences in how each is treated
 - Bio may or may not be incorporated in a general mental health room
 - Group determines that every mental health provider should have a dedicated office (for a total of 8 offices for 8 providers) and the mental health teamlet should also have a team room
- 1.7 Home-Based Primary Care Discussion
- Currently, the plan shows one 125 SF space dedicated to Home-based Primary Care but there are several flex spaces
 - Group determines that only one dedicated room is needed for storing supplies and that otherwise HBPC staff can utilize the flex offices
 - Group decides that all flex offices should be shown at the standard room size of 125 SF
- 1.8 Specialty Spaces Discussion
- Specialty exam rooms and other typical spaces to be listed at 125 SF per the plan
 - The spectacle shop can be housed in one of the flex spaces but should be identified in the plan
 - The lab increases to accommodate two dedicated phlebotomy rooms
 - A more open blood draw area is preferred without walls between the blood draw stations
- 1.9 Staff Rest Rooms
- Chris Phillips asks if there are too many of them listed in the program and suggests that some may have been double counted
 - Craig Oswald says that the staff restrooms that are shown in the plan seem appropriate
- 1.10 Conference rooms and other wrap up items
- Design team asks if the third conference room is needed
 - Maui team prefers to keep the third conference room
 - The Maui group confirms that a single janitor closet is ok for this clinic
 - Group discusses having a dedicated room for security. There are some clinics without a security room and the guard stays in the lobby, which seems to work well for that clinic
 - The group confirms that the prototype can have several flex spaces but in the test fits, these rooms should be named unless they are truly flex offices

END OF MINUTES

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LEGEND - FUNCTION

- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM/CONFERENCE
- RECEPTION/WAITING/PUBLIC SPACE
- EXAM/CONSULT ROOMS
- TREATMENT/PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION

MEDICAL EQUIPMENT
Not Enclosed



MAUI OPTION A

DRAWING TITLE

ISSUED WITH

DRAWING REFERENCE

1/16" = 1'-0"
DRAWING SCALE

12/06/13
DATE

VA CBOC SMALL
PROJECT NAME

[28319.000]
PROJECT NUMBER

A102A
DRAWING NUMBER

Plot Date: 1/8/2014 10:23:24 AM

LEGEND - FUNCTION

- POD
- OFFICES
- STAFF SUPPORT
- CLASSROOM/CONFERENCE
- RECEPTION/WAITING/PUBLIC SPACE
- EXAM/CONSULT ROOMS
- TREATMENT/PROCEDURE ROOMS
- WEIGHTS AND MEASURES
- CLINIC SUPPORT
- MECH, ELEC, PLUMB, COMM
- CIRCULATION



MAUI OPTION B

DRAWING TITLE

ISSUED WITH

DRAWING REFERENCE

1/16" = 1'-0"
 DRAWING SCALE

12/31/13
 DATE

VA CBOC SMALL
 PROJECT NAME

[28319.000]
 PROJECT NUMBER

A102B
 DRAWING NUMBER

Plot Date: 1/8/2014 10:23:35 AM

- Lots of walk-in patients with varying issues
 - Ideally a HAS clerk would be dedicated to the eye clinic
- 1.4 Space/ proposed clinic layout:
- The photo room appears to be undersized
 - Procedure room appears to be undersized – approximately a half dozen pieces of equipment need to fit into the room and space appears tight.
 - Recommend approximately 130 SF for exam room to accommodate patients with scooters and wheelchairs. Tracy added the modular 125 SF does account for those circumstances
 - Offices are necessary, but could be shared. In larger settings, private office space is needed for when supervisors need to meet with their staff, and interns/residents need a place to complete work when not in clinic (in order to not tie up exam space)
 - Tracy recommends a teaming space or touchdown area for providers and interns that are shared with other ancillary services. This was perceived well and acceptable to everyone on the call.

2.0 Discussion Outcome and Next Steps:

- 2.1 The Eye Clinic will be added to the Small Prototype with one FTE Eye Care Provider and one FTE Eye Technician and the following rooms:
- 2 Eye Exam Rooms
 - 1 Visual Fields Room
 - 1 Photography Room
 - 1 Pre-Testing Area
 - 1 Sub-Waiting Area (Dilation)

The following changes are recommended for the Medium Prototype with 2 FTE Eye Care Providers, two FTE Eye Technicians and the following rooms:

- 2 Eye Exam Rooms per Provider
- Blind Rehab Office @ 120sf will combine with a Low Vision Room and should be 180 sf
- Photography Room is increased from 150 sf to 180 sf
- Add Pre-Testing Room @ 120 sf
- Convert office space to a Team Room

The following changes are recommended for the Large Prototype with 3 FTE Eye Care Providers, three FTE Eye Technicians and the following rooms:

- 2 Eye Exam Rooms per Eye Care Provider
- Convert office space to a Team Room (expect 2 trainees in the Large)
- Photography Room is increased from 150 sf to 180 sf
- Visual Fields Room is increased from 1 to 2
- Waiting Area (Dilation) is increased from 60 sf to 120 sf
- Add a Low Vision Room at 180 sf
- Add a Pre-Testing Room @ 120 sf
- Add Office for Chief of Section Service

- 2.2 At each of the Prototype CBOCs (Small, Medium and Large), there may be Eye Care Provider training programs, especially for the Medium and Large CBOC Prototypes. For planning purposes, there should be 1 additional Eye Exam Room per FTE Eye Care Provider trainee (resident/intern/extern).

- 2.3 Dr. Yaniglos applauds the team on this process and expressed appreciation for their input being included into this study.

END OF MINUTES



IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 23 January 2014
 Meeting Date 14 – 16 January 2014
 Location University of Phoenix Conference Room, Tampa
 Purpose Design Charette Tampa

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ITEM	DISCUSSION	ACTION
	Day 1 – 14 January 2014	
1.0	Charrette – Tampa	
	<i>Attendees: Refer to list on previous page</i>	
1.1	<p>Introductions were made around the table.</p> <p>Tracy Bond gives an overview of the agenda for the next three days</p> <ul style="list-style-type: none"> • She described the growth of the prototypes from the small clinic to the medium clinic and to the large clinic 	
1.2	<p>Bill Kline discussed the decision-making process.</p> <ul style="list-style-type: none"> • The core group is the primary decision maker for the clinic prototypes and the secondary decision maker for the test-fits • The local group for each test fit is the primary decision maker for its particular test fit and is the secondary decision maker for the clinic prototype designs • Jay Sztuk spoke about the need for everyone’s valuable input but that it is the responsibility of the core steering group to make the final call to move the process forward effectively <ul style="list-style-type: none"> ○ There is a need to “know where you are” when you walk into a CBOC. The prototypes are important because they will provide uniformity and a sense of identity ○ It is important to move forward in decision making rather than going back to discuss topics that have already been covered and agreed upon • Bill Kline suggests that we could think of this as a “kit of parts” for branding and identity 	
1.3	<p>Where are we now?</p> <ul style="list-style-type: none"> • In the process of creating building standards and a kit of parts. Components of this include PACT and the extended team, waiting and reception, specialty modules, ancillary support services • 125 SF universal room in order to maximize flexibility of the clinic – rooms can be easily converted to other functions if needed • The idea of the PACT module and incremental growth from small to medium to large by adding on additional PACT modules • Block and stack – three basic blocking options to maximize adjacencies, minimize patient travel distance and to improve staff work flow <ul style="list-style-type: none"> ○ Work flow studies will help illustrate this • It is important to keep flexibility in mind because the one-size-fits-all prototype may not work for all clinic locations since the programmatic needs vary based on the local patient population demographics <ul style="list-style-type: none"> ○ A balance needs to be found between the idea of the prototype design and the customization needs and desires of each VISN and each clinic 	
2.0	Programs for Design Updates	
2.1	<p>Programs for Design Updates – Dental</p> <p>Chris Phillips gave an update on information that was gathered from dental discussions</p> <ul style="list-style-type: none"> • Dental component will prototypically be in the large clinic only and will include a minimum of two dentists • If dental is needed in a medium sized clinic, then the large dental module can be incorporated into the medium prototype • There will be a shared consult office rather than private offices • DTRs will be enclosed rather than open to allow for increased patient privacy • X-ray space will have pano only (no cone beam) – it’s not needed for the large CBOC • Telehealth room for dental care does not need to be dedicated – the room can be shared with other specialties, especially tele-derm 	

- Clean and soiled rooms need to be adequate size
 - Staff lounge can be shared as well
- 2.2 Programs for Design Updates – Radiology
- Chris Phillips gave an update on information that was gathered from radiology discussions
- Chris explains that the radiology specialty component is included in both the medium and the large prototype clinics
 - Chris points out that radiology needs can be difficult to determine because a needs assessment needs to be done for each location to understand specific requirements
 - Kits of parts for radiology needs to be especially flexible so that the individual requirements of different clinics can be accommodated and we aren't prescribing an option that doesn't correspond to needs
 - Bone density room has been discussed at 120 SF and 180 SF but the universal size of 125 SF was agreed upon
 - Specialty module equipment will be included in the next deliverable
 - Group proposed that a mobile MRI machine that would be located on a tech pad. The tech pad could be used for multiple functions including the mobile MRI
 - Group discusses women's health within radiology
 - Question posed – Is it so crucial that women's health not share any waiting and have a separate entrance into the clinic?
 - For some PTSD patients it is important because some have suffered sexual trauma
 - Chris Phillips points out that there are different tiers of women's health services based on the population size
 - A large women's health components could afford to be more separated, however often there is not a large enough women's health components to justify separate waiting and entrance so in that case it ends up being more integrated, particularly since providers in this case are not solely women's health providers but see other types of patients too
- 2.3 Programs for Design Updates – Eye Clinic
- Chris Phillips gave an update on information that was gathered from discussions
- The Eye Clinic Module is a plug-in that can be used for either a medium or a large clinic
 - Two and a half eye lanes are required per provider
 - Assumptions for the small prototype have changed and the small clinic also now includes one provider – keep in mind that this is a kit of parts that can be vetted
 - Small Clinic – One provider, Medium Clinic – Two providers, Large Clinic – Four providers
 - The group prefers team rooms rather than private offices
 - The large prototype required additional space to accommodate trainees
 - An additional equipment discussion may be needed to confirm that the space allocation corresponds to equipment needs
 - It is important to use caution when going off of the guide plates because the guide plates may not show sufficient space for a well-functioning room so it is always important to do a test-fit to test assumptions
 - Jay Sztuk points out that the guide plates also may not be updated with modern equipment and need to be evaluated with that in mind
 - Not only is a test-fit important, but we also need to have feedback from providers and work with them to determine what their current needs are
 - Suggested that the group circles back with the eye clinic group to find out more information about their equipment
 - It is important to note again that prototypes may stray from current design guides
 - Rooms will need to accommodate wheel chairs and scooters
 - The alcoves that are currently shown within the clinic for wheel chair storage are intended to accommodate equipment owned by the clinic and used for patients but parking for these may need more study
 - Also more consideration may be needed for patients personal scooters, wheelchairs

- Outlets in the alcoves are extremely important so that scooters can be charged
 - 2 feet of clearance is required around the scooters to maneuver them
- Group points out that visual impairment is the #1 reason for hospital falls so minimizing patient travel distance is important but it is especially important for eye patients
- This needs to be balanced with the feedback from the providers because due to the new system of performance based compensation, providers are demanding facilities that will allow them to perform at the highest level
- Would it be better to have three exam rooms but the patient doesn't move? This is better from a patient care standpoint because it is safer for the patients with visual impairment not to move
- However keeping the patient in the same room invites a lack of supervision when compared to patients dilating in the sub waiting area where they are more easily monitored
- Perhaps the questions to the eye providers need to be reframed in such a way that encourages the provider to consider patient centered care first
- The core group needs to come together with the eye providers to get a firm direction on this module
- Possible the PACT exam room criteria of 2.5 rooms per provider could be used – this is something that the core steering group and providers should discuss

3.0 Flow Mapping within the Small CBOC

3.1 Gabryela Passeto presents diagrammatic flow diagram showing optimal patient flow

- Group informs design team of some adjustments that would improve the effectiveness of the diagram:
 - Showing waiting as a side trip rather than a step that every patient does – the goal is that no patient will wait although the group concedes that waiting may occur under some circumstances
 - Use a graphic indicator to show whether the patient is in a room or not
 - Change the label “RN....” To “patient is roomed”

3.2 Gabryela Passeto presents 3-dimensional diagrams of Patient + Staff Flow Mapping

- Some variations in the flow will depend on the different sites
 - Patient kiosks – automatic notification that the patient has arrived
 - Privacy of the kiosks – how to we deal with directed flow of the process but patient confidentiality at the same time?
 - Will there be volunteer greeters at the front that could assist in directing patients to the kiosks? This can't be depended on because not all clinics have consistent volunteer help
 - Having someone out front generally increases the use of the kiosks but the degree of utilization depends on other factors such as patient population type. Kiosk utilization is a moving target that is difficult to predict
 - Kiosks could be made very inviting to help increase utilization and reduce stress associated with an appointment
- Further discussion with front desk staff to learn more about patient flow works and what would an optimal check-in flow look like
 - There is typically one clerk for every teamlet and the clerks rotate working at the front desk checking in patients
- The group emphasizes the importance of the check-in process and determines that more study is needed in order to have an optimal design for the prototype

4.0 Discussion of Medium and Large Prototype Specialty Modules

4.1 Medium Specialty Module Blocking

- Most specialties have a shared reception area
- Specialty blocking is intended to be flexible and the blocking layout will often depend on the

- particular clinic
- Specialty MODULE is the same size as the PACT module
- 4.2 Specialty Component: Radiology
 - The difference between the medium and large radiology components is the added ultrasound room and ultrasound toilet
 - Mammography and bone density spaces are an optional sub-space that can be added onto the back of the large components
 - Group suggests that ultrasound should be located more towards the front because it is a quicker turnaround while Rad/Flouro is more private and takes more time and should stay at the back
 - The specialty components have the ability to flex a little in order to work well with the clinic layout as a whole based on what other specialties are also plugged in
 - Any of the three medium radiology options can also be added onto the small if called for
 - Chris Phillips shows the two layouts for the large radiology module
 - There is a basic large module and also a large module with an optional addition at the back
 - The large is comprised of two rad rooms and then all of the support spaces needed to support them
 - Jay Sztuk suggests considering the modules in terms of steps 1, 2 and 3
 - Group asks if the dressing rooms and toilets shown are ADA compliant for wheelchairs
 - Tracy Bond confirms that all bathrooms and dressing rooms shown are ADA compliant and says that in the future the design team will show the turning radius on the equipment plans
 - The group briefly discusses a radiology/lab suite option where these two programs are more combined or at least adjacent since they often share staff
 - Consensus that these two departments should be collocated
- 4.3 Specialty Component: Audiology
 - Chris Phillips gives an overview of the program for audiology
 - Large clinic has three audiologists and one speech pathologist
 - Posturography and Vestibulography can be combined onto one space
 - Brooksville is a medium CBOC but it's program for audiology more closely aligns with that of the large prototype module
 - The audio exam room is the double walled room where both patient and provider go for diagnostic exams – this room is more like a piece of equipment in itself
 - Offices are important for the staff because the lighting in the booths is often too dim
 - Tech typically is in the exam/consult rooms
 - The sound booths/ suites are utilized a very large percentage of the time by both providers and patients according to the Brooksville audiologists
 - Brooksville audiologists recommend maintaining the private offices as well as the two tech spaces
 - There should be one tech for every two audiologists
 - The two audiologists and the techs can share one office – the name should be changed to team room
 - More details will be discussed during tomorrow's 3:30 audiology call
 - The Brooksville audiologists point out that even though the booths are soundproof, the placement of the audiology program as a whole should be located in order to mediate sound as much as possible
 - The group discussed the idea of Telehealth audiology
 - Telehealth for audiology could easily be shared, it does not need to be a dedicated room
 - Telehealth equipment for audiology can be on a cart
 - Brooksville audiologists say that this has been done successfully in other locations

4.4 Specialty Component: Pharmacy

- Pharmacy is shown slightly off to one side so that the waiting area associated with it can be more contained with a separate reception desk
- There are three main spaces of interaction :
 - One private space to talk with patients (can also have multiple other uses)
 - Two receiving cubbies with some degree of patient privacy
- The pharmacy is shown collocated with prosthetics due to shared storage requirements
 - The Brooksville pharmacists say that this is not necessary because they don't typically store prosthetics in the pharmacy
 - The storage area would be more for medical supplies rather than prosthetics
- Brooksville pharmacist emphasizes that out of all of the prescriptions filled on a daily basis, a large majority of these are mailed
- The large clinic will require two pick-up points and two drop off points to reduce lines
- Currently the large clinic has a pharmacist office and it sees a lot of utilization
- The pharmacy grows as the clinic does and as it grows, it requires additional storage
- Methadone clinics are not typical for the VA – these services are usually contracted out
 - Methadone clinic have an entirely different set of regulations

4.5 Specialty Component: Physical Medicine and Rehabilitation

- One physical therapist is assumed for the medium prototype
- Brooksville physical therapist recommends one private exam space and the rest of the PT space left open
- Separate space suggested for prosthetics and sensory aids including an office, a clerk office, a rep office, mail, storage, reception and receiving
- Group determines that there is a need for group classes in the medium clinic but that this group space can be shared
 - 300 SF would be the minimum needed to accommodate ten people
- Gym should be located close to prosthetics because patients will check in at prosthetics before going to the gym
 - Space is also needed for a physical therapy assistant
 - One private room for physical therapy treatments required with a sink and an exam table
 - Physical therapists say that the dressing area is not needed
 - Dr. Angela Denietolis recommends leaving it in because the staff may also use the gym after clinic hours
 - Physical therapists say that windows are very important but adequate space is far more important

5.0 . Review of Small Clinic

5.1 Tracy Bond summarizes the differences between the four different layouts shown for the small clinic prototype

- The back area and the front area show the most variation
 - Option A is the untouched version of the plan from the last Charette and the other 3 options are based on A but are developed further
 - in option B a stair has been added for penthouse access
 - the lab in B has also been updated to show wing walls and curtains – Tracy Bond points out that this combination allows for privacy as well and easy access and flow
- The group discusses police requirements
 - Police room generally used for the gun safe and video monitoring equipment
 - Police area may not be needed in all of the clinics – not all of the VA clinics in Hawaii have armed guards – in these clinics the security personnel are located in the lobby, act as greeters and patrol the parking lots from time to time
 - Tracy Bond reminds the group that the small prototype did not originally have a police office, but during the test fit in the last Charette, the group determined that

- the police office should be added to the small
- Group discusses reception layout to determine if a door is needed between the reception and the admin work area – 2 exits needed for staff safety reasons
 - Another option is to eliminate the wall between the two spaces however this may not be ideal because fax machines and mailboxes have to be in a secure area accessible only to the staff
 - Work room is intended for mail, fax and secure documents
 - The receptionists need a printer as well as they also do a lot of paperwork
 - Maui call-in participant suggests that all of the admin functions be located together
 - Continuation of police office discussion
 - Group asks to define what is meant by flex office
 - Flex offices in the prototypes can be placeholders for locally determined program or they can truly be flexible spaces used for a variety of functions as needed
 - Group suggests that the small CBOC may not need a dedicated police office and it only needs to be included in the medium and the large options
 - The only time an office would be needed is if there are armed VA police on site
 - Police office should be located at the front and ideally the police should be visible
 - For the lab program, Maui may only need one blood draw station because they only have one tech
 - Tracy Bond points out the two different locations for reception: centered or off to the side
 - The side option allows the waiting to be further away from the conversations happening at the reception desk
 - The central option is more clear and visible
 - Jay Sztuk says that the group needs to limit itself to one option rather than one stand alone and one for expansion
 - Maui believe that reception should be centrally located in the hub and the group agrees
 - The group determines that it is not essential for the group rooms and classrooms to be located off the lobby
 - Group reiterates that the police office should ideally have a view of the front of the building and the parking
- 5.2 Review of Maui Test-fit Options
- Tracy Bond explains that the B C and D options for the Maui correspond to the similarly names prototype versions
 - The side reception option works particularly well here because it creates a more centered reception in the Maui test-fit
 - CMO would be designated in one of the flex offices – these can be labeled in the Maui test fit plans and in the program
 - The training/consult room is derived from the PACT residency training room but it could also be used as a teaming space
 - The Maui clinic has eight mental health providers
 - Maui participants say that the mental health staff room should be labeled mental health rather than spec. staff
 - The team area accommodates 3 PACT teamlets and 1 specialty teamlet and extended team members for each of these'
 - Maui group says that consult nurse manager should also be included somewhere
 - It should not be assumed that the PACT nurses and support staff will also support the specialists because the specialty teamlet has its own support
 - The Maui group discusses their particular extended team members:
 - Extended team includes social worker and telemedicine techs for a total of four
 - There are 12 other team members for the 3 PACT teamlets
 - Grand total comes to 16
 - Mental health has their own separate area as shown

- Group asked for more information about teaming area layouts
 - Tracy Bond explains that different options are shown – some with 6' desk resulting in 20 seats and some smaller stations for a total of 24 seats so layouts should easily accommodate everyone
- Craig Oswald and Sharon express a concern over the “stove pipe” component that keeps the space less flexible. They would prefer if the mental health team were a little more integrated with the rest of the PACT teamlets
- Chris Phillips explained that in order to preserve the prototype design with the added component of mental health, the mental health component has to be added to the side
- Maui group says the spectacle shop needs to be added and suggests that this could go in the corner of the lobby or better yet, one of the flex offices could be used for this purpose

6.0 Discussion of CBOC lobby designs

6.1 Design team shows 3-D views of the small prototype lobby for discussion

- Patient privacy is very important when designing reception and also patient flow
- In CBOCS the receptionist typically checks patients in, acts as the information representative, does enrollment, records and beneficiary travel
 - Group emphasizes the importance of patient privacy and recommends some sort of barrier
 - Patients sometime walk up to reception to be checked in and other times will need a private place to sit and do enrollment
 - Orest Burdiak suggests a reception desk that turns a corner so that the receptionist can turn to interact with the patient coming into the clinic and leaving the clinic
- A private room is ideal for updating patient information and insurance information
- The patients are able to use kiosks to update personal information but there still needs to be another private way to do this because not all patients are comfortable using the kiosks
- Check-in area needs visual barriers so that private patient information is not visible to other patients checking in
- Groups suggests that patients may in the future use tablets to check in and that this is already being done at private facilities
- As of now kiosks are the only electronic check in option but all new clinics will be equipped with Wi-Fi so tablets do become a possibility for the future
- The paperless system requires that the clerks have two computer monitors and one electronic signature pad
- Some CBOCS do not have a travel clerk and all travel is done electronically

6.2 Group Discussion of Reception Area Location

- Tracy Bond poses the question to the group: What location is optimal for reception keeping in mind patient flow, flexibility and consistence between small, medium and large prototypes?
- HAS anticipates an additional person stationed near the kiosks to assist patients
 - There should also be an alcove beyond the main reception for private patient conversations
 - HAS explains that half of the patients coming to the clinic will have need for a more private check-in option
 - Kiosk location is very important. The kiosks can be free standing or fixed to a counter top
- Dr. Angela Denietolis suggested that a separate room could be located adjacent to the reception that could serve as a private patient interaction space as well as house the fax machine and the mailboxes
- Tracy Bond expresses a concern that taking the patient to more of a staff area may not look as professional for the clinic
- HAS points out that the reception in the medium CBOC also needs an office space for 3-4 clerks
- HAS also expresses that the private room is only really needed for enrollment and that most

- other patient check in processes are very quick and would typically be done at the reception counter with a privacy partition
- Group determines that for the medium CBOC, one large room with acoustic partitions could house the clerks and also be used for patient enrollment
 - Also required in the reception program are patient education areas
 - Tracy Bond explains that the different clusters of seating give the patient a choice of what type of environment they prefer to wait in
 - Patients may in the future be able to do some check in processes on their own devices such as updating information and participating in the “My Health-eVet (“ program
- 6.3 Design team discusses branding and identity in the CBOCs
- Tracy Bond outlines some of the different ways that branding can be achieved including glass walls, front entrance, accent walls and floor and ceiling treatments
 - Dr. Ward Newcomb points out that the waiting area looks large and that there is currently no space allocation in the program for it
 - Tracy Bond explains that that is correct that there is more space shown than is included in the program but that some of the waiting is accounted for and houses other functions as well
 - Orest Burdiak says that branding could be a very important component of the prototype because it gives the clinics a sense of uniformity
 - There is an existing VA signage guide that should be utilized
 - Environmental management is also important and chairs should be in clusters to encourage patient interaction
 - Gang seating is also preferred because it is easier to clean
 - Tracy Bond talks about areas of opportunity for branding that can be identified in the prototype
 - Group asks if there will be any discussion of handicapped parking, covered vestibules and other exterior components
 - Jay Sztuk and Tracy Bond explain to the group that these aren’t necessarily a part of this project, but they are important things to consider and may be mentioned in the narrative portion

Day 2 – 15 January 2014

7.0 Presentation and Discussion of the Medium Prototype Options

7.1 Discussion of the Medium L shape prototype option

- The eye program has been significantly expanded per Friday’s eye call but there hasn’t been time yet to adjust the plan accordingly
- Group points out that as we consider space to accommodate the staff, the “staff” is not limited to only the PACT teamlets, but the extended team members and other staff need to be considered as well
- Group discusses whether there should be a greeter desk and determines that no greeter desk should be included in the prototype because many clinics do not have a consistent supply of volunteers and an empty greeter desk would look bad
- Tracy Bond points out the tech pad that has been placed at the back near radiology per the discussions that occurred on Day 1
- Tracy also points out that with the L shape prototype option, another PACT module can be easily added at the back in order to expand the clinic while keeping the plan compact
- William Messina talks about the need for an awning over the tech pad for weather and sun protection

7.2 Discussion of the Medium two story prototype option

- The first floor shows the canteen to one side
- Dr. Angela Denietolis points out that the height and weight area should be within the clinic
- Emily Dickenson points to where it is located on the plan and Dr. Denietolis agrees that that is an acceptable location

- The second floor has some consistencies with the first for easy way finding
 - The mechanical portion could either be attached to the sides or located above in a penthouse
 - The group discusses the size of the teaming area and work stations
 - Linda Chan points out that the team area shown is larger than the team space seen that morning at the Primary Care Annex however the prototype area includes the extended team
 - Tracy discusses the conference room at the back being glass to allow sunlight to enter the back of the clinic
 - Dr. Angela Denietolis questions the horizontal layout of the work stations
 - Tracy Bond explains that the though behind them was easier movement across for the staff
 - Dr. Angela Denietolis believes the teamlets should be more separated with more space in between them
 - The group determines that the fixed plumbing shown in the Primary Care Annex teaming area is not necessary and really limits the flexibility of the space
 - Group determines that the ideal size for the desks is between 4 and 6 feet but 4 is too short and 6 is too long
 - The teamlets should be more clustered and separated from the others
- 7.3 Group discusses program locations for the two story option
- Group discusses whether the mental health portion of the program could be pulled up to the second floor
 - Dr. Mike Koopmeiners is opposed to mental health being separated from the PACT modules because this would disrupt clinic flow and also single out patients seeking those services
 - Mental health should be more embedded in PACT the way it typically is
 - There is also concern over the mental health providers having a different relationship to the team space
 - Tracy Bond suggests cutting a corridor through to give mental health better team area access
 - The group discusses the difference between primary and secondary mental health
 - Mental health that is truly integrated would not even be labeled as mental health on the plans and would instead just be shown as a consult room
 - Craig Oswald points out that the Maui clinic is unique in that it has a lot more mental health program than is typical for a small clinic and that is why there is a separate mental health area
 - Maui has a 1:1 ratio of mental health to primary care providers
 - Group suggests that the mental health then could be set up similarly to the primary care PACT with their own central teaming space
 - Dr. Mike Koopmeiners points out that the decisions about the teaming area really depend on how much of the providers time is spent in the consult rooms and if most time is spent in there, then a private office may be justified instead of a shared space
 - Dr. Koopmeiners brings up the idea of shrinking the central bay size and adding a second team area for the mental health providers
 - Dr. Ward Newcomb agrees with Dr. Koopmeiners and also says that all of the mental health rooms should have two doors for safety reasons

8.0 Discussion of Grid Size

- 8.1 Tracy Bond explains how the program at the front and the back of the clinic will be affected if we go to an irregular grid
- The square footage available for program is significantly reduced
 - If mental health is instead added onto the side without the team area as shown in the second option, then the whole reason for changing the grid is lost
 - Square footage is also lost to the added circulation corridors
 - The loss of the front and back program also takes away exam spaces that are needed
 - Creating 3 team areas for a 2 PACT module confuses that criteria and breaks down the module – clinics will be less standardized and the prototype is less effective

- Three 20' bays is essentially the same as two 30' bays so the overall building footprint is not being reduced so the construction cost will not decrease
- Dr. Mike Koopmeiners points out that if the CBOCs move toward 50% virtual care, then the current prototype would serve the needs of the patients well
- Dr. Angela Denietolis explains that the future of Telehealth is difficult to predict because while the VA is pushing for increased Telehealth, the end result is an overall increase in appointments rather than replacing in person appointments with virtual
- Jay Sztuk asks the group if we can move forward with the 31'-10" grid and group agrees that this is the optimal grid size for the prototypes

9.0 Continuation of Medium Prototype Options Discussion

9.1 Tracy Bond presents the linear option for the medium prototype for discussion, pointing out the 3 PACT layout

- Larry Janes points out the trade-off between putting mental health in the center vs the embedded option
- Linda Chan says that at some VA facilities, mental health is put onto the side and given its own separate entrance
- Tracy Bond points out that in the linear scheme, there could easily be two reception areas and the patient would have a choice of which to use
- The staff pod for the mental health area will be adjusted to match the way the PACT team area is shown
- Steve Distasio asked why mental health would go to either side if it is supposed to be embedded?
- Larry Janes explains that the placement of mental health could allow for a separate discreet entrance if desired by the clinic
- Group determines that mental health adjacency is not critical and the preferred location is near PACT, not with the specialty components
- Reception should be moved forward and should include a specialty and an ancillary check –in area

9.2 Whole Group Working Session – L shape Medium Prototype

- Steve Distasio asks why the specialty module is not rotated the same way that PACT is
- Tracy Bond responds that the thinking behind this is that the L shape limits travel distance for patients and begins to create an identity where commons is shared between all departments
- Dr. Angela Denietolis explains that difficulties can arise from a single shared reception because the specialties might have different check in procedures
- Steve Distasio points out that the L shape offers the best footprint for patient travel distance, the exterior access and offers the most flexibility for adjacencies and expansion
 - He says that he would like to see a large version of this prototype for Black Hills and also likes the curved wall
 - Bill Kline points out that another version of this could be a two story option with the third PACT module on the second floor
- Dr. Mike Koopmeiners asks where employee parking is anticipated in this option and suggests that it could be in the knuckle or off of the PACT close to the staff entrances
- Dr. Angela Denietolis says that she really likes the L option but feels that the current layout still puts the specialties in a maze
- Dr. Denietolis also says three offices are needed for clinic management and should be shown in the plan
- HBPC should also be a team room rather than separate private offices

9.3 Whole Group Working Session – Two Story Medium Prototype

- Pharmacy located on the first floor for easier access
- Group also determines that lab and radiology should be on the first floor also

- Rick Bond asks if canteen could be moved to the second floor to which Sylvia Wallace responds that the optimal location for the canteen would be on the first floor where there is the most traffic but that it could potentially move to the second floor if necessary
- Dr. Koopmeiners anticipates that the specialties will see higher traffic than the PACT primary care
- As currently shown, the first floor program is larger than the second floor
- Group discusses splitting up PACT and determines that this would be ok if there were more than two modules but if there are just two then this is not optimal because the two PACT modules would typically share nursing staff
- Steve Distasio suggests a patio space on the second floor for staff to utilize on breaks and leave a placeholder for future expansion of the clinic
- Dr. Koopmeiners expands on this idea and suggests that meditation gardens and other outdoor alternative healing areas could utilize roof space

10.0 Rick Bond – Head of Operations with CFM speaks to the group

10.1 Rick Bond gives brief personal background and shares some thoughts about the process

- Standardization is good, design-build can be good if done correctly and accountability is very important
- VA currently has 27 stalled leases that need to be addressed and this effort will play a huge role in the way that we serve veterans in the future
- Not everyone will leave this process with exactly what they want but “pretty good” is good enough to make a start
- Timothy Bertucco asks about how to deal with the 10000 SF local leasing threshold because with the prototypes the ate being developed, this option may not work any longer
- Rick Bond says that when the prototypes are complete, the small prototype should become the new threshold
- There is a push to build bigger for increased flexibility and shell space is often reserved adjacent to the clinic
- Rick Bond points out that there is cost associated with shell space and how much are the VA is willing to pay for shell space
- Orest Burdiak points out that a lot of the things that this group is developing for the prototypes does not conform to the criteria so how can the criteria be enforced during construction. There is a gap in the understanding between leasing, the VHA and Office of Interiors
- Branding remains an important issue
- Larry Janes follows up to wonder how this project will transition to execution since this is a new concept for the VA and another phase of this effort is the real property service and discussions with contracting
-

Day 3 – 16 January 2014

***Please reference the notes on the attached PDF for additional details from today’s discussion**

11.0 Discussion of Medium CBOC Prototypes

11.1 Tracy Bond presents the L Shape medium prototype options with updates per the Day 2 discussions

- The group determines that home based primary care does not need a dedicated space since they are only at the clinic for part of the day but they do require a dedicated storage area
- Dr. Angela Denietolis also points out that home based primary care should not be given priority for office spaces with natural light for the same reasons that they are typically only there in the morning and in the evening
- Chris Phillips suggests that we take away their private office but we leave them a team room where they can have dedicated storage

- Dr. Angela Denietolis says that in some cases, home based primary care would need a private office for a regional supervisor or someone else in a similar role
 - The team space would not necessarily have to be a room but could be more of an area similar to the PACT teaming area
 - Six home based primary care providers need to be accommodated
 - Home based primary care would still need a dedicated storage space
- Tracy Bond enquired about the quantity and type of storage
 - Dr. Koopmeiners wonders if they truly need dedicated storage or whether they can share storage space with primary care
 - Dr. Denietolis feels that they need to have their own space because they have a lot of equipment
 - Chris Phillips suggests a standard 125 SF room for HBPC storage
 - The group determines that this is acceptable
- Emily Dickenson asks the group to clarify the terminology for specialty module vs. ancillary
 - Up to this point the design team has referred to it as “specialty”
 - Dr. Denietolis feels that another term would be more suitable
 - The group determines that we will now use the term:
Ancillary Diagnostic Services Module
- Steve Distasio points out that logistics has unique requirements for storage and services and merits further discussion
 - Is the proximity of the loading dock to the pharmacy an issue?
- Chris Phillips recaps the program requirements for the pharmacy and the information that was gathered during the pharmacist earlier in the week
- Steve Distasio points out that it is important for pharmacy supplies to be transported via a back hallway and it is important that logistics staff do not handle pharmaceuticals
 - Steve Distasio emphasizes the importance of talking with the logistics people and getting buy-in from that group
 - This will help the core group market the prototype to everyone having received input from all parties
 - Dr. Denietolis suggests that the group have a logistics call similar to the calls with the other specialty components and show them plans for both the medium and the large clinics
- Ward Newcomb makes the point that this group is not designing the clinic of the future and that there isn't enough time in this project to go into every detail of what the clinic of the future should be
- Bill Kline says that some language should be included such as “This group recommends that these prototypes be put through an intensive lean process”
- Ward Newcomb says that the VA needs to build and test options to see how the clinic really work and then from this information design the clinic of the future
- Steve Distasio explains that the ideal for logistics is to have one central supply point and the group should discuss how this should be executed in the program
 - A central supply point eliminates waste because the facility knows exactly how much of everything it has rather than different doctors ordering duplicates of the same thing and having medical supplies expire
- Tracy points out the staff break room that is included in the program for the canteen and asks what its purpose would be since we have other staff lounges for each group
 - The break room is really more of a staff dining area and allows doctors to have a separate space away from the patients
 - Chris Phillips explains that the net grossing factor can skew the interpretation of the numbers seen in the program and a note should be added to reduce confusion
 - Canteen program can be pushed out to the lobby as shown on the current floor plan
 - Chris Phillips clarifies that the important question is whether this canteen staff break room is a redundant space

- Enough seating needs to be allocated for the canteen and this is something that needs to be checked because the group suspects that there is not enough currently in the program
- Chris Phillips points out that the canteen is part of the commons area so it's a soft space that can be flexible and accommodate more seating for the canteen
- Steve Distasio asks how we account for square footage for snack carts, etc?
- Chris will review what canteen types are available but points out that canteen designs should be flexible because each site has to do a study to assess what they can support
 - For example, a medium clinic could theoretically support a large canteen
- There could be a large space with lounge seating rather than dining tables
- Steve Distasio emphasizes the importance of the connection between the canteen and the lobby so that it can flex no matter what canteen type is selected
- Bill Kline reiterates that the canteen seating can be combined with the lobby seating
 - Chris Phillips explains that the program and the prototype plan need to work back and forth and by the end of the process the two will match
- Dr. Koopmeiners stresses that healthy eating is an important part of patient education
 - There could be opportunities to incorporate healthy eating classes in the canteen area
 - The layout could be done in a way that allows a portion to be partitioned off
- Tampa would like a 775SF canteen with possible outdoor seating
- Dr. Koopmeiners asks about placement of VBA to which Chris and Tracy explain that those types of functions would utilize the flex offices already included in the plan
- VBA could be considered a component and the group should speak with them to determine what their needs are
- Jay Sztuk points out that these is separate funding for these other organizations so this group shouldn't spend too much time figuring out their spaces
- Steve Distasio says that VBA is more of a business function and Tracy Bond explains the VBA and others can share the group rooms
- Dr. Koopmeiners suggests no more than 1-2 flex offices should be allocated for VBA
- Bill Kline brings up additional questions about the canteen area
 - How does the on stage and off stage relationship work
 - Sylvia Wallace says that there are many deliveries rather than everything arriving at once and that all of the canteen functions do not need to be collocated. Food preparation and deliveries can happen in an area separate from the on stage area

12.0 Discussion of the Brooksville Test Fit

12.1 Discussion of the Brooksville test fit program

Chris Phillips goes through the programmatic requirements for Brooksville with the group

- Chris explains that there are some differences between the program for the medium prototype and the program for Brooksville
- Acquisition and material management are fairly close to the prototype but the Brooksville program includes exterior gas storage at 200 square feet – group has determined that this is not needed and it will be taken out
- Dr. Angela Denietolis suggests that we call the team space PACT P.C./ Specialty in Brooksville's plan but also in the prototype
- The Audiology component in Brooksville is more similar to the large audiology component
- Chris recaps the main takeaways:
 - The small CBOC will have a Telehealth room that is shared and also a hearing aid modification room
 - The medium will have two audiologists each with one consult room and one suite
 - The large will have three audiologist each with a sound suite, and two consult rooms
 - For Brooksville the vestibulography and the electrophysiology can be combined

onto a single 200SF space and Chris will confirm that this is consistent in the large prototype program for the component

- Clinic management no longer needs a support equipment room because they can use the general copy room
- All offices will now be shown at 125 SF for consistency
- In terms of the lobby Chris Phillips thinks that some of the spaces listed are already embedded in PACT and redundancies should be eliminated
- Storage room/ equipment storage is really wheelchair storage
- The group prefers not to label the toilets male and female
- Group thinks handicapped or family toilets should be provided off of the lobby
- Steve Distasio suggests that there could be one universal toilet that meet all of the requirements
- Tracy bond points out that the toilets off the exam rooms don't need to be enlarged for baby changing stations so universal bathrooms may not be optimal
- Group determines that all single toilets should be unisex
- Family and bariatric toilets are show as 75 square feet and other toilets are 60 square feet
- Bariatric toilets will also be required in the bathrooms
- Brooksville currently requests 4 blood draw stations although there are only 3 in the prototype for the medium
 - Dr. Denietolis says that for Brooksville 2 regular and one bariatric blood draw would be sufficient
 - The prototype should also be changed to match this

12.2 Discussion of Brooksville lab bathrooms

Tracy points out the specimen toilet attached to the lab that is intended only for drug testing and the second patient toilet off the hallway with a pass through window

- Dr. Denietolis has concerns over this layout because it creates an opportunity for patients to swap samples since they are not always being monitored
- Dr. Ward Newcomb says that typically pass through windows have been taken out of most VA clinics because of these concerns and because patients claim that samples are missed
- Dr. Denietolis does not support putting a pass through window into the lab
- Small clinic currently shows one specimen toilet with a sink outside the room
- The medium currently shows the same with an additional patient toilet opening into the lab
- Dr. Koopmeiners says that some specimen toilets have an exterior valve controlled by the lab staff that cuts off the water to the bathroom or they add a blue agent to the toilet
- For now the consensus is to leave it as drawn but remove the pass through from the other toilet room

12.3 Continuation of general Brooksville Program discussion

- Brooksville group discusses removing the dressing room and adding that square footage back into the gym but decides against it in order to keep the prototype more intact
- The police room needs a gun safe at 40 square feet that could either be a built in or a vault
- Rita Mercier suggests that the gun vault could also serve as an evidence locker
- Dr. Koopmeiners says that he'd like the toilet near the police room to remain there because if they are holding someone, they don't need to bring them back into the clinic to use the facilities
- Dr. Denietolis believes that there are too many offices listed for prosthetics because in the large clinics she has visited there is just one office and one storage room
 - Dr. Denietolis will follow up with Brooksville prosthetics staff to determine what their exact space needs are
- Both Brooksville and the prototype show two dressing rooms for ultrasound but Dr. Denietolis says that Brooksville doesn't need two and will discuss with Chris
- Dr. Denietolis says that the service organizations do not need 60 SF for storage and that they can instead use the shared clinic storage

- Dr. Denietolis says that the volunteers don't need a designated room but they will need storage
 - Chris Phillips suggests that we use a flex office for the volunteers
 - OI&T – Office of Information and Technology Rita Mercier says they only need one space for both repairs and storage
 - The group determines that the biomed room needs to be designated and cannot be shared
 - Consensus is that there will be one biomed repair room and one storage room
 - The equipment storage and the tech room can be combined into a single 200 SF space
 - An IT room is needed in the small CBOC
 - The number of comm rooms needed varies based on the layout
 - Engineering just needs to be one space and fire room should be included with the mechanical space
- 12.4 Discussion of the Brooksville Test fit Plan – See attached PDF with additional details
- Dr. Denietolis questions whether the mental health teaming area will see as much utilization as we imagine but this could vary from one clinic to another
 - Chris Phillips suggests making the team area shorter and keeping it at the top and Dr. Denietolis says that she likes that concept for Brooksville
 - Tracy Bond explains that the design team has assumed one computer work station per PACT in the group appointment rooms which would mean four in the medium
 - Dr. Denietolis thinks that there should be a minimum of two
 - According to one of the calls the group room calls for four
 - Comm and electric room could be pulled to the front where the staff lounge for the canteen used to be
 - HAS should move up to the front behind the reception
 - Dr. Koopmeiners asks about the dead end corridors and Tracy explains that these are intended for possible future expansion opportunities and agrees that they could be filled in
 - The reception area would benefit from further study – the design team will come up with a few schemes and then Dr. Denietolis will vet the options with her HAS team
 - The group agrees that we will go forward with the one central reception option with some way to visually differentiate between the primary care and the ancillary specialty care sides
- 12.5 The group discusses the growth from the medium to the large
- The L shape option is a great footprint and incorporates a lot of flexibility for expansion
 - The mechanical piece could move and a third PACT could be added in that spot
 - The VA audience is important because the prototypes need to be carefully presented so that no one thinks they are being forced into a prescribed plan
 - The prototype is intended as a base plan that is still flexible
- 13.0 Group Discusses the two Story Medium Clinic with Updates by the Design Team per the Day 2 Conversations**
- 13.1 Tracy Bond presents the revised plan
- Tracy shows how all of the requested program changes have been made which makes the floor plates even more uneven with most of the program on the first floor
 - If the clinic is located in an urban place, the design would need to be optimized by making the two floors even
 - Group discusses the possibility of two different options for the medium – one two story urban option and one non-urban optimal option
 - Group agrees that from a constructability perspective it would be better for the medium clinic to be two stories however, since the prototype is meant to be optimal this group should select the best solution
 - Tracy Bond suggests that the group only consider a two story option for the large prototype
 - Some existing CBOCs are already two stories and they deal with it by breaking up the PACT modules

- Jay Sztuk says that that option isn't optimal and should not be considered for the medium
- Tracy Bond agrees that now that we have addressed the two story scenario and have solid reasoning against it, this group can move away from it and develop only one floor options for the medium prototype

13.2 Group Discusses Equipment

- Tracy explains that she wants to go over key aspects of the equipment layouts with the group
- The idea is to have universal exam rooms that are all laid out uniformly and then supplies are bought in on mobile carts

14.0 Discussion of Exam room Layout

14.1 Tracy points out that three different door options are shown on the typical exam room layout slide

- Emily Dickenson points out to the group that when you put sliding doors on the patient corridor side, you can't put handrails in the corridors and this may not be the best patient centered approach from a safety standpoint
- Dr. Newcomb says that handrails aren't needed and have not been put in to most of the clinics he has seen – thinks that the group should recommend sliding doors for the prototypes instead
- Linda Chan says that the doors should swing in to give more privacy to the patient
- Group says that the door openings for the exam rooms should not be aligned
- Linda Chan expresses concern about the sink placement
- Tracy Bond agrees that that is not the ideal location for the sink and explains that these layouts are based on existing VA design guides
- Tracy Bond reemphasizes the limitations of sliding doors on the patient corridors because of the inability to then include handrails
- Dr. Denietolis believes that having handrails in the corridor is very important for patient safety
- It is suggested that barn doors could instead be placed on the inside of the exam rooms
- Group discusses having built in cabinets that are double sided and can be accessed and filled from the staff team area
- Group is interested in the Herman Miller Compass system which is a modular rail-hung system with interchangeable components
- This discussion was abruptly halted as the time allotted for the conference room was over and the group had to vacate the room. The next deliverable will include the layouts for the VA representatives to provide comments for change.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319 VA101F-13-J-0176:

Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	14 - 16 January 2014
Location	VISN 8 - University of Phoenix Conference Center - 12802 Tampa Oaks Blvd., Temple Terrace, FL 33637
Purpose	Charrette Tampa

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- all of the clinics
 - The small clinic does not necessarily need to provide diagnostic services, but there would still need to be treatment services such as hearing aids programming and fitting.
 - The specialists recommend that the small CBOCs have 1 audiologist for hearing aid services
 - One tech is recommended for every two audiologists, however, a 1:1 ratio would be ideal
- 1.5 Audio –Telehealth and Accessibility Discussion
- Group suggests that Telehealth would allow for increased audiology capabilities, particularly in the small clinic prototype
 - Audiology group agrees that Telehealth would work well and is already done in some locations
 - For diagnostic, sound suites are needed , but hearing aid service could be supported with a Telehealth component
 - Specialists emphasize that all sound booths must be wheelchair accessible, which requires either a ramp or a recess in the floor to accommodate soundproofing – the thickness is about six inches (so 6 inch recess or 6 inch ramp height)
- 1.6 Chris Phillips asks to confirm the requirements for medium prototypical audiology component
- Two audiologists, no vestibulography, no electrophysiology
 - One shared group therapy room
 - Two audio therapy offices (although the guide only calls for one)
 - Audiology group says space is needed to see patients and to program hearing aids
 - Dr. Angela Denietolis asks if one audio therapy room can be called something else
 - Audiology group prefers to keep it as shown because it allows two patients to be seen at the same time
 - Chris Phillips asks if there would ever be just one audiologist or always two?
 - Audiology group says two are preferred but there could be a single audiologist in a small CBOC
 - Chris Phillips recaps that for the medium prototype, there should be a minimum of two audiologists and one health tech
 - A hearing aid modification room is needed – not currently shown in the module
 - Audiology group says that two audiologists require two suites and two exam/ consult rooms
- 1.7 Audiology Telehealth and Small Prototype Audiology Needs
- Chris Phillips says that the medium CBOC contains 6 general Telehealth rooms – will that satisfy needs for audiology Telehealth or do they need a dedicated space for Telehealth?
 - Audiology group says a dedicated Telehealth room is not needed and that tele-audiology is typically done with a cart
 - Tele audiology would most likely be done in the small prototype clinic rather than the medium
 - The Small Clinic also needs to have a dedicated hearing aid modification room and a Telehealth room that can be shared
 - Small will also need access to a shared group therapy room
 - 50 SF is adequate for equipment storage. Equipment and storage = hearing aid modification
 - Shared reception is fine for all clinic sizes
- 1.8 Discussion of Large CBOC Audiology Module Requirements
- Chris Phillips says that the large CBOC currently shows 3 audiologists – do the audiologists work in pairs?
 - Audiology group says that the audiologists do not need to be in pairs
 - Audiology group explains that the audiologists will see about 30% of the primary care patients
 - Group decides after discussing the possibility of 3 audiologists and 1 tech, that 3 audiologists and two techs would be more appropriate in the large CBOC
 - This necessitates 3 suites and 3 exam/consult rooms
 - The hearing aide modification room is still needed and all of the other shared spaces are also still needed and can remain shared

- Chris Phillips points out that he has included spaces for speech pathology, vestibulography and electrophysiology
 - Audiology group explains that vestibulography and posturography aren't always required and in fact posturography is typically NOT included in the program. Posturography can be removed from the prototype
 - Audiology group also says vestibulography and electrophysiology should remain in the prototype module and the speech pathology room should remain as well
 - Vestibulography room and exam/consult rooms should have sinks in them
- 1.9 Audiology Group Outlines other Requirements
- Vestibulography room and exam/consult rooms should have sinks in them
 - Adequate storage is important and should be double what is shown to 100 SF in the large clinic
 - Exam rooms should have sound protection against ambient noise
 - The placement of the audiology module within the clinic is important in order to mitigate the noise – audiology should not be placed next to electrical and there should be extra insulation in the walls or some type of sound proofing system

END OF MINUTES

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- Recommended hotel is the Homewood Suites by Hilton Mall of America
2261 Killebrew Drive
Bloomington, MN.55425
 - Pete informed everyone the room does not have video conferencing or audio capabilities available. It will have internet connectivity
 - Pete also advises all attendees to dress warmly as temperatures are significantly colder than usual for this time of year
- 1.5 MEP Discussion:
- There is no need to show a stair to the mechanical penthouse. The VA will not pay for that space. Roof access can be handled via an exterior ladder or developer provided stair on the exterior of the building
- 2.0 Next Steps:
- The upcoming 3-day charrette is hosted in Minneapolis on 11-13 February 2014.
 - Meeting with Police and Security is scheduled for 29 January 2014 to confirm their space requirements
 - Meeting with Logistics is scheduled for 4 February 2014 to confirm their space requirements
 - The bi-weekly call on 11 February is cancelled as it conflicts with the Minneapolis charrette
 - Dr. Denietolis would like to allow the nursing staff to review the submittal and provide additional feedback on the room layouts.
 - Jay stated the 3D views of spaces we have created in presentations are very helpful for discussions and have been perceived well by all.
 - The Progress Report Submittal will be published on 31 January 2014. Gabryela will be sending all meeting attendees throughout the course of this project a sharepoint site login and access instructions to download the submittal for review.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 29 January 2014
 Meeting Date 29 January 2014
 Location Teleconference
 Purpose Defining Space Program – Police + Security

PARTICIPANT	COMPANY	PHONE	EMAIL
Jay Sztuk	VA CFM, Director, Cost Estimating Service	202-632-5614	Jay.sztuk@va.gov
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Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com

ITEM DISCUSSION ACTION

1.0 Space Programming: Dental Services – 0900 -0945

Attendees: Jay Sztuk, Keith Frost, Tracy Bond, Gabryela Passeto and Chris Phillips

- 1.1 Jay began the discussion giving a brief project background to Keith Frost. The team is looking to the decision makers for their guidance to make a decision about the programmatic requirements for Police and Security within the Small, Medium and Large CBOC Prototypes being developed. Jay explained the idea is to standardize a core component to reduce the amount of ground work that must be done when starting the design of a new CBOC.
- 1.2 Keith Frost stated currently there is no requirement that mandates a security or police presence in any facility other than a VA Medical Center. Implementation of security practices is typically left up to the facilities to determine based on their geographic location and unique security needs.
- 1.3 Keith Frost described the program requirements for Security and Police:
 - Under HSPD12 – Physical access control systems will be required in all facilities
 - Policy states that when police has a space in a clinic, it must be immediately accessible and visible by patients upon entering a clinic/main lobby area
 - A safe is required in all settings for locked up items. Police officers do not take guns home and are required to store weapons under a two lock control. The safe is also used to store and protect the integrity of any evidence
 - Control panels for cameras are typically located in the communications closets. The monitors will be located at the reception area. 1 monitor can show up to 6 cameras.
 - Cameras are only placed in common areas and public corridors.
- 1.4 Tracy stated in some clinics and medical centers the police operations and holding/safe are typically separate. Keith agreed this is an optimal scenario and would recommend the CBOC layout mimic this standard.

2.0 Discussion Outcome and Next Steps:

- In the Small CBOC, the police operations will remain in the front of the clinic, located off the vestibule. If monitors are located there, only the back of the monitors can be seen through the windows



- The safe will be located near the staff locker rooms/logistics space.
 - Staff can change in the locker rooms and officers can load their weapons off-stage, not in the public eye
- The holding room will also be located in the logistics area to facilitate police transport through a secondary staff entrance. This will avoid having security transfer disgruntled patients through the clinic's public area
- The medium CBOC should accommodate approximately 4-5 officers while the Large CBOC grow to approximately 8 officers

END OF MINUTES

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 26 February 2014
 Meeting Date 11 – 13 February 2014
 Location VISN 23 Headquarters; 2805 Dodd Road, Suite 250, Eagan, MN 55121
 Purpose Design Charette Minneapolis

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ITEM	DISCUSSION	ACTION
	Day 1 – 11 February 2014	
1.0	Charrette – Minneapolis	
	<i>Attendees: Refer to list on previous page</i>	
1.1	The group is welcomed to Minneapolis and introductions were made around the room.	
	Tracy Bond gives an overview of the agenda for the next three days	
	<ul style="list-style-type: none"> • Discussion of progress since the charrette in Tampa • Go over the comments received on the progress report submittal • Review of the small CBOC plans • Discuss public areas in the Small, Medium and Large CBOCs and optimal configurations for those areas • Discussion of Medium and Large prototypes • Third day will focus on the test fit for Rapid City 	
1.2	Where are we now?	
	Tracy Bond gives an overview of the progress the group has made towards completing the prototypes and test-fits and what tasks still need to be accomplished	
	<ul style="list-style-type: none"> • The Small and the Medium CBOC prototypes are close to completion and just need refinement • The development of the Ancillary Diagnostic Service Modules is ongoing • Both of the test fit layouts for the Maui and Brooksville clinics are complete • The design team submitted a progress submittal on January 31st and will continue to receive comments until February 14th • The key remaining dates for this project are the pre-final deliverable due March 7th, the final presentation in Washington DC on March 25th and the final submittal is due March 31st 	
1.3	Jay Sztuk brings up some points for the group to keep in mind about the decision making process during this charrette:	
	<ul style="list-style-type: none"> • Jay Sztuk emphasizes the importance of not revisiting decisions that have already been agreed upon by the group during previous meetings in order to keep the process efficient and moving forward in a timely fashion • Larry Janes explains his continuing concerns over the size of the teaming area. He feels that it is still too large and that the 18' width seen by the group during their visit to the Paolo Alto mock-up was an adequate amount of space • Jay Sztuk says that he disagrees and that he and others in fact did think it was too small • Gary Fischer reminds the group that the design of the prototype can yet be further refined after this project has ended • Dr. Angela Denietolis points out that once the Primary Care Annex is complete, they will be in a position to provide valuable feedback to the VA based on how well their clinic is operating. <ul style="list-style-type: none"> ○ They have two different door configurations for their exam rooms that they can compare and contrast ○ Their teaming spaces are more narrow than what is shown in the prototype so they will be able to give feedback on how well it works for them • Dr. Ward Newcomb expresses agreement that the only way to know for sure what works and what doesn't is to build clinics and test different ideas 	

2.0 Discussion of Updates to the Programs for Design

Chris Phillips goes over the updates that have been made to the PFD based on previous calls and meetings

2.1 Police and Security:

- Police have been located in the front of the building within the vestibule area per Keith Frost, Chief of Policy and Infrastructure Protection Division Office of Security and Law Enforcement's guidance on 29 January 2014:
 - This gives them greater visibility to the outside of the building while maintaining a view of the common areas also
- Keith Frost expressed that they could use the Communications room as a place to store their weapons since it is a secure room rather than having a dedicated room for the gun safe.
 - Rita Mercer points out that for Office of Information and Technology (OI&T) sites, the clinic will not have access to the Communication rooms because the security of those spaces are controlled by the building management in leased scenarios. Anytime a security officer needs access, he/she would need to be let into that room by someone else which does not seem ideal
 - Dr. Angela Denietolis agrees that in a leased space, the VA would not have direct access to the Communications room
- The medium clinic would require 4-5 officers and a large clinic would require 8 officers
- Sharon Espina expresses concern for the plan showing the police holding area at the back of the clinic because it would put potentially violent persons closer to other patients

2.2 Logistics Updates

- Chris Phillips reiterates that the goal is to have supplies located in one place to increase efficiency and reduce medical supply waste
- Dr. Denietolis receives confirmation that there is no separate storage for prosthetics in the Small CBOC clinic
- Chris tells the group that there was an infection control expert on the phone during the logistics call as well and that this person had requested a dedicated space for cleaning medical equipment
 - Presently in small CBOCs, some equipment is cleaned within patient corridors which is not ideal
 - Chris suggests the prototype is set up so that equipment cleaning could be done in the staff area and would not be done in patient corridors
 - The group agrees that the prototype is set up this way and therefore no need for a medical equipment cleaning room in a small CBOC
- Chris reminds the group there is no soiled utility room listed in the program and that in a previous meeting it was decided by this group that none is needed because most soiled items would be disposable
- Chris points out that there is a clean supply room
 - Sharon Espina says that at Maui neither room is needed because biohazards are picked up weekly
 - Dr. Denietolis agrees that in the future, CBOCs are trying to get away from using any linens and use disposable gowns instead
- Dr. Mike Koopmeiners asks whether integrated health has been a part of any discussions thus far because they may offer a different point of view
- Tracy points out that medium and large clinics would be likely to have more of a need for a clean and soiled room than a small CBOC
- Chris summarizes that a loading dock will be added to the small prototype but not a soiled utility room. Jay disagreed and said that a small clinic would not require a full loading dock but rather a grade-level pad.

3.0 Progress Report Submittal Review Comments: General Comments

3.1 Tracy explains that most of the comments received to date have been more specific and so far there have not been any general comments received for the design team and opened the floor to the group to discuss general comments on the submittal:

- Dr. Koopmeiners explains that the CBOCs are a patient centered operation and that PACT represents more than just primary care
 - Chris Phillips points out that specialties are included in the planning assumptions
 - Dr. Emler says that things should be defined in terms of the patient rather than the PACT or even the teamlet
 - Tracy agrees that the sizes need to be carefully defined in the Final Report to show what defines each type but also indicate the ability to flex within each category
- Larry Janes reacts about the relationship between the CBOC and the PACT nomenclature
 - The nomenclature should correspond but the CBOC design guide is currently being updated so some of the naming conventions are inconsistent
 - Dr. Denietolis explains that according to the PACT definitions, 1 teamlet = 1,200 patients and for the purposes of this project we should stay consistent with the old definitions. It will be up to each locality to evaluate whether what is prescribed works for them
 - Tracy emphasizes that scalability is very important in this process and we show with Maui how the prototypes can adapt to accommodate site specific program requirements
- William Messina explains that the number of exam rooms is typically driven by the number of number of teamlets and that the ratio is consistent from medium to large
- It was suggested that the nomenclature change from Small, Medium and Large CBOCs to One PACT, Two PACT and Three PACT CBOCs
- Dr. Denietolis clarifies for the group the differences between the primary care mental health embedded in PACT and the specialty psychiatry services
 - There is one list of diagnoses that the primary care mental health providers treat and all other diagnoses are handled by specialty psychiatrists
 - Chris points out that if there is a specialty psychiatrist in the small clinic, then they typically have a designated exam room that is labeled whereas the primary care mental health is labeled as consult rooms
 - Dr. Newcomb explains that one of his personal goals is to promote integration and make sure that mental health services are integrated even more then they are currently and never separated from the other types of care
 - William points out that there are some cases where a degree of separation can be a good thing, such as high acuity patients who really shouldn't be integrated with other patients and clinic functions
 - Sharon expresses concern that in the Maui test fit, the mental health providers don't appear to have their own teaming space
 - Dr. Denietolis and Chris point out that they do have a group room in the back and also explain that in Maui's case, those providers each have their own exam room.
 - Dr. Denietolis points out that it will be up to the clinic to determine how these spaces will be used

4.0 Small CBOC Prototype Program for Design

4.1 Chris Phillips goes over the PFD for the small CBOC prototype

- Gary Fischer expresses concern about the layout of the lobby and waiting area
 - He believes the vestibule is too small and will not act as an effective air lock
 - In some current CBOCs the waiting areas are almost unusable because they get so cold from the air coming in through the vestibule
- Chris says he will note that the eye component in the small clinic is optional in the PFD, to match the plans
- Jay suggests that a plug in module would be great for the VBA if they needed to have a presence and would allow them to be “plugged in” without disrupting the clinic space

4.2 Discussion of Small CBOC Prototype Plan

- Tracy explains there are two plan options currently being shown for the small prototype; Options A and B.
- Option A shows the police pulled to the front and a cut through to better facilitate expansion out to the side
- There are also differences in the options with the group room layouts and in the lab layout
- Dr. Denietolis says that one toilet needs to be at least 75 SF so that they can be family toilets and all toilets should be unisex
- Tracy shows how having the police in the vestibule frees up more space to have a flex office and/ or expand the toilets
- Tracy asks the group what they think about the scooter alcove shown in the plans pointing out that it would have outlets to charge scooters and adequate space to park them
 - The general consensus on the scooter alcove is that while nice, the alcove is not necessary and most prefer to gain that space back for other uses
- Gary Fischer questions the size of the blood draw area as it is currently shown
 - Tracy explains that the area is called out in the program for 120 SF each but it is shown closer to 110 and that still seems large
 - Dr. Denietolis states that in the Primary Care Annex, their blood draw areas are 80 SF and that seems to be large enough
 - Chris suggests the design team reduces all blood draw areas to 80SF, but points out criteria is 120 SF
 - Gary Fischer says that the criteria is out of date anyway to it is acceptable to deviate from it when appropriate
 - Sharon suggests that the blood draw chairs have the ability to lean back in case a patient passes out and also suggests that modular walls be used to increase flexibility of the space
 - Chris Phillips explains that the original 120SF likely derives from the fact that there used to be a counter top in the blood draw station
 - Rita Mercer suggest moving the door of the specimen toilet to allow for more counter space
- Tracy reviews Option B for the small clinic prototype noting that it gives an extra exam room
- Sharon Espina suggests shifting the women’s health rooms down and putting the nurse manager more towards the front
- Dr. Newcomb states women’s health rooms should be same handed
- Chris reminds the group the small prototype only has a HAS office and the Maui test fit there is a nurse manager and a CMO, not a part of the prototype
- Most small CBOCs will not have a resident so the training room may not be necessary to include in the prototype design and could instead be used as another flex space
 - Flex offices are mostly located near the front of the clinic since typically they would be used by specialty organizations
 - Tracy Bond explains that the reason the training room is at the back is to make both layers of the back of the clinic glass, allowing sunlight to enter the back of the clinic and the teaming area

- Gary expresses a concern over the procedure and the clean room in this particular option are taking away from prime exam space
 - Tracy explains the procedure room is located towards the back because we thought it would get less utilization than the other rooms
 - The procedure room can also be utilized as a bariatric exam room or a third women's health room
 - Sharon agrees and says that in Maui, the room is often used for spinal cord patients
- Dr. Koopmeiners suggests the way the rooms are named should be as generic as possible in order to promote flexibility and adaptation since every clinic is different and every clinic will adapt the prototype plan anyway to suite its needs
 - Dr. Newcomb explains that is the reason the guide use bubble diagrams rather than floor plans
 - Chris agrees the plans are flexible and reiterated why the group has chosen to proceed with universal room sizes
- Tracy says the design team will adjust the plans to make the women's health rooms same handed
- Jay asks the group which layout is the optimal layout to show in the submittal
 - The group agrees the procedure and women's health rooms should be pulled to the front
 - The group also agrees all of the exam and procedure and consult rooms should be same handed
 - The training room should be renamed to **training/admin** because there will not always be utilized by residents. If there are residents they would typically want them to be within the team work areas

4.3 Chris discusses the module for the optional eye component for the small prototype

- The eye clinic will have two exam rooms with eye equipment in them

5.0 Discussion of Maui Test - Fit

5.1 Tracy points out that the layout selected for Maui is more similar to the Small Prototype – Option A:

- The admin office in the plan will be renamed to the HAS office
- The two other offices at the front will remain flex spaces
- Jay asks if there are too many flex offices – group decides that there aren't too many but if needed could eliminate one to accommodate other Service Organizations
- Tracy explains the Maui test-fit is different because of the additional mental health providers that is not seen in a typical small clinic

5.2 The Small Prototype is discussed further

- The group asks if the BGSF for the small prototype is over or under what is called for
- Design team determines that the BGSF is not greater than what is called for
- Chris, in response to a question by Gary, says that the departmental gross for primary care is 1.52 and that this is what the VA criteria is in SEPS and is not an editable field
- Jay says that the key to keep in mind is that the prototype design has not exceeded the square footage prescribed

6.0 Discussion of the Medium CBOC Prototypes

6.1 Tracy presents the block and stack diagrams for the medium prototype options

- Tracy reminds the group that per the last charrette, the group has decided to move away from the two story option for the medium clinic because it was not optimal to split the program into two floors
- Tracy discusses the linear blocking diagram and points out opportunities for expansion and added ancillary services
- Tracy presents a new third option, Flare, for the medium prototype with a central concourse or atrium
- Group asks what the pros and cons are to making the clinic longer

- Dr. Denietolis says the Primary Care Annex is very long because it has six teamlets, but she does not recommend having a clinic any longer than that
 - Chris brings up the point that in all three of the options shown, the same modular approach is utilized and the same kit of parts that is aligned with the PACT concept that has been developed
- 6.2 Medium Prototype CBOC Program for Design
Chris Phillips goes through the Medium Clinic PFD with the group
 - Chris reiterates that there are four teamlets per PACT and the PACT module remains fairly consistent from small to medium
 - Dr. Denietolis expresses concern over the one dietician and one social worker listed per PACT, stating that really in a two PACT design two of each aren't needed
 - Dr. Emler says she actually does have two social workers in her two PACT clinic and points out the criteria represent the ideal. If in fact the optimum number of staff is available, then there needs to be space allocated for them within the clinic
 - Chris points out that if there is one instead of two, the clinic just gets an extra flex or consult room that can be used for something else
 - Chris mentions the canteen program is taken from the design guide
 - Chris Phillips states the medium clinic has space allocated for home based primary care and also includes a team space and storage space for six providers
 - There are also eight mental health providers in the medium CBOC and two group therapy rooms
- 6.3 Group discussion of the mobile tech pad implications
 - The group suggests a retractable canopy to go over the tech pad
 - Tracy asks if a vestibule is needed to serve the tech pad side of the clinic and if so, this needs to be included in the clinic square footage
 - Linda Chan says that patients could still use the regular radiology check-in and use the internal hallway to get to the tech pad
 - Tracy brings up the idea of a vestibule once more and adds that a waiting area of some type could be considered
 - William Messina says currently patients are gowned and then have to walk outside to go over to the trailer. This is not an ideal scenario and there is not enough space in the mobile unit to change
 - The group agrees that it is not optimal for patients to have to walk outside in their gowns
 - Larry Janes said that it would mostly be MRI and CAT scan patients, so it makes sense for these functions to be associated with radiology
 - Dr. Koopmeiners agrees that there should be some sort of internal waiting space associated with the tech pad patients, but this doesn't necessarily need to be a dedicated waiting space
 - Group suggests that the tech pad could be yet another module or kit of parts that can be plugged into the clinic as needed
 - Jay Sztuk says that for the purposes of this project, showing a location for a potential tech pad is probably sufficient
- 6.4 Group Discusses the Medium CBOC Linear Prototype Option
 - This is a two PACT module plus ancillary diagnostic services module
 - The front bar, similar to the small, includes meeting areas, group rooms and conference space
 - Dr. Denietolis confirms the pharmacy layout has incorporated her change requests and points out that the reception desks need to accommodate three people
 - Jay reminds the group that the L option for the medium was the preferred layout per the last charrette
- 6.5 Group Discusses the Medium CBOC L- Shaped Prototype Option
 - Tracy points out the sub-waiting areas that have been included
 - In Brooksville, the reception desk is in the same location, but a second, smaller desk has

been added for Specialty Mental Health

- Dr. Koopmeiners says that he doesn't agree with separating out the mental health and worries that it gives a stigma to the patients
- Tracy Bond explains that the sub-waiting area for mental health allows them to use the same front entrance while at the same time their waiting area can be highly supervised
- Dr. Denietolis emphasizes that the mental health patients must be supervised, however she is concerned that the segregation of the mental health patients has negative implications
- Dr. Koopmeiners refutes it is a mistake to say that mental health patients need more supervision than other patients and all of the waiting areas need to be supervised.
 - Elderly patients with heart problems need to be supervised just as much as patients that can be unpredictable
 - Rather than physical supervision, video monitoring could be utilized so that the entire area is covered
 - Dr. Denietolis says that video monitoring is good but it's not enough. There also needs to be a physical presence in the lobby in case someone needs to intervene
- Tracy suggests removing all of the sub-waiting areas as a result and have all patients wait out in the commons/lobby
 - Rita Mercer and others agree and say that they dislike the idea of patients waiting "behind the scenes" back within the clinic. They should instead wait out in the public space until they get taken back for their appointment
- The group expresses some concerns over travel distances for staff coming out into the waiting to get patients
- Dr. Denietolis thinks that the reception areas are too small and thinks they should be redesigned to accommodate six clerks at a time.
 - Tracy Bond agrees that as shown, the reception areas are not large enough to accommodate six people
 - Group reminds everyone the check-out process is also important, and should be considered as well.
- Dr. Denietolis feels more privacy is needed in the team area on the rotated wing and thinks the patient areas having access to the teaming space is not ideal
 - Tracy suggest putting in additional doors to separate the patient areas from the staff areas and Dr. Denietolis agrees that would be a good solution
- Chris points out eye and audiology do not have a team area but share a team area with other specialties.
- Linda Chan asks whether there really needs to be an additional sub-wait area in the gym
 - Tracy says that is the direction the design team has been given so far and it is intended to be shared between PMR and prosthetics
 - Dr. Denietolis informs the group that PMR and prosthetics have both said they need to be next to each other and that this layout is designed to their specifications
- Group determines the pharmacy does not need an exterior wall and could be shifted
- Group discusses several different ways to reconfigure the pharmacy, prosthetics and PMR
- Chris suggests some of the flex offices that are shown can be eliminated
- Tracy says she will look at the PMR and prosthetics and come up with some options to discuss tomorrow with the group
- Tracy reviews the changes to logistics per the logistics call:
 - The layout here is shown as very flexible
 - The logistics area is designed so that it can easily expand and not impact the clinical modules.

6.6 Discussion of the Brooksville Test Fit and Review of the Layout

- Women's health is located in the back in the knuckle
- Dr. Denietolis requests that the procedure rooms be brought toward the front as discussed

earlier in the day and would also like to include whatever layout is worked out for PMR and prosthetics into this plan

- Rita reminds the group that the police can't be in the MEP area in a leased building
- Tracy states the team will rework this area and that there are 4-5 police required for a medium clinic
- Dr. Denietolis expresses concern about separating the team work area from the patient corridors and Tracy agrees to add additional doors to separate the two zones more definitively

6.7 Discussion of the Medium Flare Option

- Tracy Bond explains that some of the advantages to this design include a more compact patient waiting area where patients are able to be monitored more easily
- There is potentially less natural light in this option but there could still be glass at either end as well as skylights and clerestory windows
- The group determines that a major downside to this option would be that the providers have to cross the commons area to get from one side of the clinic to the other which opens up opportunities for patients to grab them and ask them questions, disrupting the clinic flow
- William Messina says that the design team needs to work on the reception desks and that all of the ones he has seen seem too few and not large enough
- Tracy Bond agrees that the reception areas still need more work
- Tracy Bond suggests that the kiosks may help to alleviate some of the congestion at the front
- Dr. Angela Denietolis says that two clerks is not enough for a five provider team and that while the kiosks may help with the check in process, there are many other check in and check out functions that cannot be done at a kiosk

Day 2 – 12 February 2014

7.0 Charrette – Minneapolis

Attendees: Refer to list on previous page

7.1 Tracy provides an overview of the agenda for the day:

- The Group will discuss some of the key outcomes from day 1 and the changes the design team has made to the layouts based on these discussions
- Typical room layouts and equipment contents will be discussed along with proper naming conventions

7.2 Discussion of Maui Test Fit Lab Component Revisions from Day 1

- Tracy Bond presents the new layout for the lab and explains how Sharon's comments have led to the reconfiguration
 - The blood draw stations have been redrawn at 80 SF
 - The lab has been reconfigured to allow for better access from the clinic side in case a patient passes out and staff needs to get to them quickly
 - The patient toilet has been reconfigured to incorporate the pass through window that Maui has requested
 - Waiting chairs have been added for patients to use
 - The lab area is not 150 SF to match the program
 - William Messina asks what the protocol is when a patient faints in the lab to which Sharon Espina explains that the patient would typically not be moved but the added door will allow staff to respond faster
- Tracy asks the group if they prefer this lab and suggests that if so, the design team should replace the lab in all of the other layouts to match this one
 - Linda Chan agrees that this lab layout is preferred and the rest of the group concurs

7.3 Discussion of Mental Health Waiting Revisions from Day 1

- Tracy talks about flipping the group rooms
- An additional corridor has been added to the mental health side to provide an additional route

- for staff to go get patients from the waiting area
 - Tracy brings up the idea of using pagers to alert patients that a room is ready for them in order to cut down on staff travel distances
 - The sub-waiting area have been removed and mental health patients will now wait in the commons area with all of the other patients
- 7.4 Discussion of PACT module Revisions from Day 1
- Procedure room and women's health rooms have been moved down to the front and are now same handed as was discussed during the meeting yesterday
 - The Small prototype will also show the rooms reconfigured this way
 - Sharon Espina asks about changing the configuration of Maui to show the rooms in the order that she prefers
 - Tracy agrees that for Maui, the design team will show the layout that Sharon prefers
- 7.5 Discussion of Pharmacy, PMR and Prosthetics Revisions from Day 1
- Option 1
 - Sub-waiting remains in the same corner and the entry is through the reception area
 - PMR and Prosthetics are still collocated as requested
 - Prosthetics and PMR storage is combined into one space
 - Option 2
 - Pharmacy is pushed up next to reception
 - 3 flex offices and spectacle shop have to move to another spot which puts the spectacle shop further away from the rest of the eye functions
 - Option 3
 - The one flex office and the spectacle shop do not have to move in this option
 - The pharmacy shifts up slightly
 - The storage is shared with the gym in this option but it is located across the hall
 - In this option the prosthetics patients are waiting out in the common area near the pharmacy
 - Sharon Espina asks to add a door to the gym that would align better with the flow - It was suggested that instead, the gym be extended over and the exterior door becomes an egress door only
 - Jay Sztuk asks whether the linear room shape is the ideal configuration for storage - Tracy responds that the room shape should work well for storage and Dr. Denietolis agrees
 - - Dr. Emler points out that the length of the storage room may actually be an asset because everything can be seen easier
 - Rita Mercer points out that typically the patient would wait inside the prosthetics area, which is more of a suite and should be connected to the gym, She also feels the door from the office to the main waiting area is not needed
 - Linda suggests changing the name of the prosthetics office to Pros Office/ Fitting and making it 125 SF
 - The group consensus is the office should be hard walled rather than partitioned
 - Linda questions whether the pharmacy consult spaces should connect to the pharmacy
 - Chris Phillips and Tracy Bond explain that not joining the two spaces is intentional and that is was based on the direction given to the design team in Tampa that those spaces specifically should not connect
 - Jay asks to confirm is the storage is shown at the correct size
 - Jay suggests that the prosthetics office move to where the pharmacy consult is currently shown in order to keep the waiting area open and continuous
 - Group agrees that they would like to see the layout that Jay Sztuk suggested

8.0 Discussion of Public Spaces

8.1 Tracy shows the group 3 dimensional views of the front facades of the small, medium and large prototype clinics

- Sharon would like to add an outdoor seating area to the small prototype
 - Tracy says that the design team will work on getting some different views together that show the overall plan and more of the site
- Jay reminds the group to consider the security requirements of the patient drop off areas

8.2 Public Spaces Discussion: The Entry Vestibule

- Tracy explains that the design team will make sure that the vestibule design can function to block direct drafts
- Tracy also points out the wheel chair storage area at the front is intended for clinic owned wheelchairs, not patients' personal scooters or wheelchairs.
 - Sharon asks the rest of the group how many wheel chairs their clinics typically have and wonders if the area shown in the plans is larger than necessary
 - Dr. Denietolis and Jay explain that the chairs fold up and that there appears to be more space than is needed
 - Gabryela Passeto adds that the wall is there to partition off the area to keep the chairs more contained and less visible so that the vestibule looks less cluttered
 - Linda thinks that the wheel chair storage area is too wide and should be narrower
- Others in the group are concerned about egress issues if the area is too narrow for a person to go in and fold/ unfold chairs
- Tracy explains that the design team made the area a little larger to allow people to maneuver the chairs without blocking the exit or getting in people's way
- Tracy also explains that the vestibule doors will be offset in order to create a better barrier between indoor and outdoor air
- Jay k and Dr. Emler agree that the air tightness of the vestibule is very important

8.3 Public Spaces Discussion: Common/ Waiting areas

- Tracy explains to the group that there will be different types of seating areas to provide options for the patients
- Family waiting will be in a corner so that they can be separate from other areas
- Dr. Emler says that privacy for the kiosks is important
- Tracy describes how the placement of the kiosks allows for some privacy, but also can be seen by the clerks in case patients need assistance using kiosks

8.4 Public Spaces Discussion : Medium Common Area/ Waiting

- Tracy shows how the layout for the medium clinic waiting areas expands on the small clinic layout
 - The outdoor seating areas adjacent to the canteen
 - Pharmacy and PMR areas will be updated to match what has been previously discussed
- Jay asks to confirm if the seating count corresponds to the total required for the clinic
 - Tracy confirms that the seating shown reflects the correct totals listed in the program
- Sharon asks if the reception area has a place for women to breast feed
 - Dr. Denietolis says there is an area for that purpose in the large CBOC, but not in the medium or in the small
 - Dr. Emler clarifies this is not the same as the staff lactation room because patient and staff areas need to remain separate
 - Carla Belle Alexander explains that there are specific guidelines for lactation rooms and they must include a refrigerator and a sink
 - Sharon suggests there could be a small partitioned off area within the commons area
 - Jay reminds the group that patient and staff lactation areas are separate and

- agrees that there should be a secluded, screened-off area within the patient commons area
 - Tracy agrees that the design team will include this and also points out that currently no staff lactation room is shown either
 - Carla Bella Alexander suggests the design team include a room for this, but call it wellness or employee health to indicate that it accommodates a variety of staff health needs
 - Tracy shows kiosks located in front of the reception desk rather than spread out to allow the receptionists to monitor their use
 - Tracy reminds the group that we are calling the lobby area the commons because it is intended to accommodate many different functions
 - Chris adds that all of the commons functions are driven by the criteria outlined in PACT
 - The group wonders if all of the waiting space is needed
 - Dr. Newcomb says it is impossible to know how efficient rooming the patient will be in practice and if later it is determined that not all of the space is being utilized, some of the area can always be converted to other uses
 - The group should think about how this might be done when working through the layouts
 - Tracy reminds the group that although it still shows up in this plan, the sub waiting for mental health will be removed
- 8.5 Public Spaces Discussion : Large Common Area/ Waiting
- Tracy begins by stating there is more growth to the commons area in the large layout
 - The resource center is marked by partitions rather than hard walls to keep it open and visible but identified
 - Currently there are four different reception areas shown
 - Dr. Emler suggests that a centralized check in would be better for patients
 - Dr. Denietolis explains that clerks have a wide range of distinct skill sets and PACT clerks do different things and have different training than specialty clerks
 - A centralized check in could be better because if a clerk can't come to work one day, there are others there that can cover them
 - Tracy explains that up to this point, PACT reception has been kept separate from the ASDM reception
- 8.6 Public Spaces Discussion : Furniture Discussion
- Tracy shows the group images of different seating options for the commons area and recalls that the group had said that armed chairs and ganged seating were important to the group per the Charette in Tampa
 - Dr. Denietolis says there are some seats that have outlets and an arm to hold laptops in Primary Care Annex
 - Emily Dickinson points to where these are shown on the plan and asks the group if the VA has any sort of furniture document that the design team should refer to in the submittal
 - The group doesn't seem to be aware of one so the design team will follow up with Orest Burdiak
- 8.7 Public Spaces Discussion : Reception
- Tracy presents 3D layouts of reception areas along with plans
 - The first option shows kiosks at the front and private conversation space to the side
 - The second options shows the kiosks attached to the front reception desk
 - The third option shows an office workroom as one large space rather than a separate office and staff work area
 - The fourth option shows no kiosks at the front and a single office and admin space
 - Dr. Denietolis says that this would work well for the small clinic, but the medium and the large do not need cubicles behind every reception. There should be one central

- space in the layout for administrative tasks and services
- 4 to 5 clerks are needed in the medium and the large reception
- Tracy Bond says that for special cases, the reception area can be adjusted as is appropriate to accommodate additional services that are provided in the clinic
- Dr. Denietolis and Sharon agree that three alcoves are plenty and that they should all be accessible with low counters
- Jay recalls that in other meetings it has been said that the copier and fax need to be in a closed room and the rest of the group confirms that they must be in a lockable space

9.0 The Medium Prototype CBOC

- 9.1 Tracy explains the PACT typically has one reception desk serving two PACT modules plus the mental health component
- Group determines that clerks could be trained to perform both primary care and mental health services so staffing off the reception desk is flexible
 - Dr. Denietolis states 4 clerks should be adequate for a typical small clinic but for Brooksville, 6 are needed due to their additional program
 - Jay poses a question to the group: What is the ideal distance between clerks at the reception desk?
 - The distance between patients checking in is also an important factor to be considered
 - The group also points out that spouses will often accompany the patients
 - Tracy suggests that 5' would be a generous amount and 3'-6" would be a minimum distance
 - Dr. Denietolis suggests all of the check -in counters be low to accommodate wheel chairs
 - The group agrees that all counters will be low and ADA compliant
 - Tracy asks how many chairs should be provided and suggests that there be at least one chair
 - Sharon requests there be bariatric chairs be located at least one check-in station
 - Tracy asks the group if workrooms and offices should be separate
 - Dr. Denietolis suggests that the prototype show one combined space
 - Sharon agrees that in Kauai, it was left open and the clerks really liked it
 - Chris asks that the group keep staffing in mind when considering the reception layouts because there may not always be enough people on any given day to staff all of the desks
 - Dr. Koopmeiners explains that the sizing of the front depends entirely on the throughput
 - Dr. Denietolis says that it is not ideal to have patients queuing up behind a patient who is arguing over travel pay so there should be an area for sensitive conversations to occur
 - Dr. Emler suggests that the check in clerks should be shared across primary care and specialties and even though this is not currently done, it could easily be done if the clerks receive training for both, She also points out that different clinics will have different ancillary services and therefore different needs
 - Dr. Denietolis is concerned if the reception desk is widened, the hallways will have to shift and will no longer align
 - Dr. Koopmeiners questions whether it is really important for the hallways to align and suggests that it isn't really necessary or conducive to patient flow
 - Tracy agrees and suggests that aligning the hallways isn't very important to the flow of the clinic
 - Jay wonders if two hallways or needed or if there could just be one entry into the clinical space
 - Sharon strongly recommends that the group keep the two hallways in case patients need to be separated
 - Dr. Koopmeiners also thinks that two hallways are optimal due to the large amount of patient traffic

10.0 Large Program Review

- 10.1 Chris Phillips reviews the defining characteristics of the Large (Three PACT) CBOC Prototype.
- 10.2 A&MM remains the same as in the Medium prototype, as it is again dependent on its remoteness from other facilities.
- 10.3 One PACT is larger, because teleretinal is not repeated in each PACT module.
- 10.4 Canteen for the prototype is Model 3, Option 1. Sizes in actual projects will be dependent on actual volume generated.
- 10.5 The prototype assumes off-site sterilization for the Dental Clinic.
- 10.6 The Biomed area is the same as the Two PACT Prototype. This space can serve as a space for a dedicated or travelling biomedical staff member.
- 10.7 Dr. Koopmeiners states the family toilet rooms need to have at least one on the lobby side. PACT's have 4 family toilets already in the program.
- 10.8 The Lab should go to four chairs plus one arm on the wall, minimum
- 70% of lab appointments are fasting; adding another 1-2 draw stations for "rush hour" would be helpful.
 - Dr. Koopmeiners noted that extended hours in the large CBOC will be Monday through Friday 7am – 7pm, and 8 hours on Saturday.
- 10.9 Larger CBOCs can have chemotherapy.
- The Pharmacy plans in the prototypes have been left as large open spaces to allow for individual site customization.
 - Should not be included as line item in prototype PFD
- 10.10 In the Multi-specialty Clinic, face-to-face patient encounters are happening in exam rooms.

11.0 Large CBOC Prototypes

- 11.1 Tracy presents the large (three PACT) CBOC prototypes and explained their growth from the small and medium prototypes.
- 11.2 Discussion of the Large CBOC Two Story Prototypes
- Tracy explains both two story options split the three PACT modules, with two PACTs on the first floor and the third on the second floor split with Mental Health specialty.
 - Dr. Denietolis says ideally the three PACT modules would be collocated and not on separate floors. One PACT module on another floor can work, but is not optimal.
 - The third PACT on the second floor could become Women's Health with a connection to mammography and specialty care.
 - Women's Health rooms will not only be used for providing care to female Veterans. Pap smears are now required only every three years, so female Veterans are primarily coming in for Primary Care exams.
 - The deliverable narrative should address these exam rooms' versatility as unisex exam rooms.
- 11.3 An employee wellness room is needed in the Medium and Large CBOCs. This will serve as the employee medical break room, suitable for use by lactating mothers, diabetics or other staff requiring a private area to attend to needs.
- 11.4 John Henderson expresses concern that the two collocated group rooms will not be large enough to accommodate the all-staff meetings of the larger CBOCs.
- More of the group and shared medical appointment rooms could be located adjacent with movable partitions to allow for larger group meetings. This necessitates a higher ceiling.
 - The rooms should be located along the front "bar" to allow for the possibility of borrowed light from the lobby area. This location would also allow for after-hours events and group use outside of clinic hours.
 - The narrative should note the sensitivity to acoustic privacy needed at these areas.
 - All shared rooms require infrastructure for telehealth and v-tel capability.
- 11.5 The Large L-shaped Prototype is the Medium L with an additional PACT module and extended ancillary.
- The current plan shows two reception points. Individual sites will do what is best for their

- clinic, so the scalable reception concept will enable each site to do that.
 - The ancillary module lengthens, and the Pharmacy wraps around to anchor the module.
 - Dental and Audiology should not be adjacent.
 - Pharmacy to have three receiving windows and two dispensing windows. An additional ADDS machine is not necessary in another portion of the clinic, there will be alcoves for immunizations. The Pharmacy should allow for patients to stop by on their way out.
 - Dr. Emler stresses the importance of the ability for specialists to talk with primary care providers. The narrative should explain the flexibility of the team work area to overlay specialty providers into PACT team areas.
- 11.6 Linda Chan asks if an option where Mental Health is fully integrated can be shown.
- The team work area is not specific to Mental Health or PACT; it's a flexible space for any provider. Tracy emphasizes that it's a collaborative space where multiple specialties are encouraged.
 - The plan is flexible enough, but the field needs options within standardization to meet philosophical way to deliver care.
 - Dr. Denietolis reminds the group that Central Office leadership did not support full integration. The prototype should reflect input of Central Office Mental Health SME.
 - Test fits can show full integration

12.0 Break out session for Rapid City

- 12.1 Chris Phillips began reviewing the general programmatic elements for the Rapid City test fit. Chris noted that the test fit is using components from the medium and large CBOCs. John Henderson – suggests that the design team and Black Hills Team go through a detailed review of their program and not in the larger group format.
- Pharmacy – Use from Large Prototype. Confirm number of drop off and pick up windows.
 - CB Alexander suggests the test fit show 5 spaces, 3 at receiving and 2 at dispensing.
 - OIT – Data Center is a unique requirement that is not in prototype.
 - Black Hills will need this data center to support two facilities.
 - PMR – Use PMR from Medium Clinic. Prosthetics space not in Rapid City PFD, but will consider keeping from the prototype.
 - Lab – Use Lab from large prototype. May need to grow main lab space by up to 150-200 sf depending on configuration and chemistry.
 - Radiology – Use Large prototype. Do not include Mammography. Pulmonary Screening replaces the U/S. For now, keep the same number of dressing rooms (2 per Rad Room).
 - AMMS – Use Large prototype. Consider increasing storage to 1000 sf and revise the Issue area per the large prototype at 100 sf.
 - Dental – Use from Large prototype, x-ray area will not include a cone beam.
 - Audiology – Chris Phillips noted the specialty group request that a minimum program include one booth, one exam space, one hearing aid fitting and a group space – this may be shared.
 - Engineering – Use from Large prototype
 - EMS/Lockers/Showers – Back of house space by loading dock and AMMS. This area will require additional spaces to be added
 - John Henderson stated that the showers are a requirement within their contract with EMS.
 - Mental Health – Use combination of Large MH module and use of extended PACT Team members to satisfy the requirements for the exam consult spaces.
 - Voluntary Service will be located near the front of the clinic in the flex spaces.
 - PACT – Use Medium; Rapid City has 6 teamlets; round out the 8 teamlets with overflow MH and Specialty
 - Specialty – Use Large Multi-Purpose Specialty Clinic and 2 teamlets from PACT...or use PACT Module as Specialty Module. This will be further discussed on day three.

- Support Areas will be placed throughout the prototype. The scope washer will be located in the support zone most likely in a flex space.
- Business Office will be located to the front of the clinic as previously discussed.

Day 3 – 13 February 2014

13.0 Charrette – Minneapolis

Attendees: Refer to list on previous page

- 13.1 Tracy Bond gives an overview of the agenda for the day
- Review Rapid City PFD break-out discussion from yesterday
 - Group work session for Rapid City test fit
 - Next steps discussion
- 13.2 Chris Phillips summarizes the PFD discussion
- Pharmacy to be the large component with three drop-off and two pick-up windows
 - OIT is a unique mission to be a data center as support
 - PMR is equivalent to the medium exercise area
 - There is no prosthetics in PFD, but will show in test fit as placeholder
 - Lab to be large component and can expand as functions need expanding.
 - Radiology uses the large component as a base. Rapid City does not have mammography or ultrasound, but has pulmonary function and bone density.
 - AMMS uses large prototype, but with a larger storage component
 - Dental is the same as the large component
 - EMS (Environmental Management Service) is unique to Rapid City. It is located in the back of house area, so can grow to meet the PFD.
 - Audiology is smaller than prototype components, but Rapid City team is still evaluating Audiology need
 - Mental Health is larger than the prototype components at 16 coordinators. It is dependent on collocation of the domiciliary.
 - Business office should have travel, benefit, means testing, IDs. It will become a component for the prototypes.
 - Conference space is enlarged to support conference capability for others.
- 13.3 The Rapid City CBOC is between 25-45 minutes from the Medical Center, at an unchosen site.

14.0 Rapid City test fit working session

- 14.1 Conferencing space should be adjacent; technology cannot be relied on to run two separate rooms for the same meeting. The expanded conferencing capability at Rapid City is primarily for staff, so not as crucial to be adjacent to the common area.
- 14.2 Specialty Care moves very quickly, so proximity of provider to exam is crucial. Connecting corridors between teamlets will help. The connecting corridors will be added to all prototypes.
- 14.3 John Henderson asks how the test fit factors into final approval of this project.
- Jay asserts the purpose of the test fit is to prove the prototype does or does not work. CFM initiated this to help deliver projects in a timely manner, on-budget. It is not a VHA initiative.
 - Tracy explains that the process will be explained more clearly in the narrative of the deliverable. The programs will vary for each test fit, so the program cannot be standardized. But if every design is re-thought, the time savings will not be there.
- 14.4 Dr. Denietolis explains that there is a point of diminishing returns in trying to put every last person in a team work area.
- Rooms “off to the side” are for single provider interactions (without nurse)
 - Patient encounters where nursing is required have priority of adjacency to team work area.

- Dr. Denietolis' clinic will most likely have extended team members covering multiple PACTs; however, Dr. Koopmeiners' clinic will not.
- 14.5 Rapid City will be running 5-6 specialties concurrently during core hours.
- 14.6 They will run the entire clinic from a single large reception desk. It is easier for staffing and patient wayfinding. Six staff positions should be sufficient.
- 14.7 The vestibule / police component lends itself to branding. The canteen should be on the same side of the vestibule in options.
- 14.8 A follow-up call will be had to review discussed plan changes.

15.0 Next steps

- 15.1 The L-Shaped is the preferred scheme. This will be elaborated in the narrative.
- The other schemes will be carried forward.
 - The primary factors driving the preference are the expandability and flexibility. Travel distances are improved and reduced for patients over linear schemes.
 - There is increased "frontage" space along the common area
 - The wayfinding is improved for patients and staff overall.
 - While one story is preferred, many clinics will have to be two stories.
- 15.2 Veteran involvement in the project is questioned. At this stage, a National Service Organization could be contacted to review.
- 15.3 The reception areas require further refinement.
- The scalable desk with private alcoves will be useful at all clinics
 - The business office at Rapid City could be a common component, located near the reception area. It will be called Business Services. Patient Advocate can also be placed in this office.
- 15.4 The March 25, 2014 meeting will be the final time to "button up" the submittal. It will involve the whole team.
- 15.5 Defining characteristics should be explained more robustly in the deliverable to prevent confusion.
- 15.6 Design team will follow up with test fit stakeholders: plans by end of February 21 and follow-on call the week of February 24.
- 15.7 Scalable integration is the key word going forward.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

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PROJECT: 28319 VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	11 - 13 February 2014
Location	VISN 23 - 2805 Dodd Road, Eagan, MN 55121
Purpose	Charrette Minneapolis

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 24 February 2014
 Meeting Date 26 February 2014
 Location Teleconference
 Purpose Review Rapid City Test-fit Layout

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ITEM DISCUSSION ACTION

1.0 Review Rapid City Test-fit Layout – 1200 - 1300

- 1.1 Overall introductions were made for the various offices.
- 1.2 C.B started with the discussions and concerns they are having with the first draft of the layout.
 - Based on the test fit, the major concern is the lack of several exam rooms having two doors into the exam room.
 - Black Hills is struggling with the kit of parts concept and plugging in the bits of Legos to make the test fit work.
 - The Specialty Clinic and the Behavior Health corridors are a concern, Black hills referred to these as “green towers” for this discussion with the lack of a second door.
 - Black hills asked the design team to look at the 3 PACT model to allow of all of the exam room to have a second door into the rooms.
- 1.3 Tracy explained that making most the exam rooms with two doors will add at least one bay in width to the back bar. The front portion will not be affected.
 - As discussed in the previous work sessions, the PACT model will always have a double loaded corridor with one bank of rooms not having this double access.
- 1.4 Gabryela shared the two different options discussed at the Minneapolis works session.
 - Option 1 has the 3 teaming areas
 - Option 2 has a separate mental health corridor and a separate specialty corridor. These two areas do not have the double door into the exam rooms.
- 1.5 Pete noted concern about the two rows of “hinterland” exam rooms without direct links to the teaming areas. A connection to the teaming spaces is needed due to the travel distances and the indirect link to teaming areas.

- 1.6 Tracy asked if these rooms could serve as the consult rooms and still keep the specialty clinic as it's shown.
- C.B. stated that each exam rooms and mental health should have double doors.
- 1.7 Tracy suggested that logistics piece (AMMS, OIT, MEP) portion can shift one bay to accommodate the added space needed for the third teaming/work area, allowing the exams to have the double doors.
- 1.8 C.B. asked how many people were in the teaming areas.
- 24 plus the extended team
 - CB stated the Rapid City is more of a 2.5 PACT and should look at the 3 PACT modules. There is a concern of adding building area if its not needed.
- 1.9 The design team will lay out the exam rooms to have the two door access and we will reschedule a conference call to discuss the revision.
- 1.10 The design team asked if the mental health is to be re-planned to be incorporated versus separate area.
- Consensus was yes.
- 1.11 C.B asked for the building area for the test fits, the design team will include this in the next plan iteration.
- 1.12 C.B stated she had other comments to the plans that will be forwarded to the design team after the call.
- These additional comments will be review by the design team and discussed on the next phone call.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 5 March 2014
 Meeting Date 25 February 2014
 Location Conference Call
 Purpose Bi-weekly Project Update

PARTICIPANT	COMPANY	PHONE	EMAIL
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Tracy Bond	SmithGroupJJR, Project Manager/Architect/Medical Planner	202-974-5161	tracy.bond@smithgroupjjr.com
Gabryela Passeto	SmithGroupJJR, Architect	202-974-0830	gabryela.passeto@smithgroupjjr.com
Ashley Andersen	SmithGroupJJR, Architect	202-974-4516	Ashley.andersen@smithgroupjjr.com
Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com
Bill Hoffman	URS, Mechanical Engineer	202-872-0277	Bill.g.hoffman@urs.com

ITEM DISCUSSION ACTION

1.0 Project Update – 1400

Attendees: Jay Sztuk, Pete Yakowicz, Linda Chan, Dr. Denietolis, Tracy Bond, Gabryela Passeto, Ashley Andersen, Chris Phillips, and Bill Hoffman

1.1 The purpose of the call is to update attendees on the project status, address any outstanding issues/concerns, due-outs and next steps.

1.2 The discussion on the Equipment List and Typical Room Layout:

- Chris Phillips and Linda Chan are in the processing of reviewing comments and providing resolutions to the Equipment Lists for inclusion in the Pre-Final Submittal.
- Additional off-line discussions for the Typical Exam Room will be held later in the afternoon with Dr. Denietolis and Linda Chan with the design team
- Gary Fischer stated a meeting had been scheduled for 26 February 2014 with Women's Health champions to review the prototype layout for Women's Health Exam Rooms. He will forward the meeting invitation to the design team

1.3 Linda's request for Concept of Operations for included in the Pre-Final Submittal:

- Tracy stated the developing a Concept of Operations was not part of this project scope and currently not included in the submittal.
- If included Chris estimated there are approximately 39 functional areas across the three prototypes and each would require a Concept of Operations. However, Section 2.2 already includes the information to date on these functional areas. Added a scope modification would need to be issued in order to complete this work.
- During the discussion Jay agreed that this was not in scope and will follow-up with Linda to understand why she wanted to include the Concept of Operations in the deliverable

- 1.4 Maui Test and Fit Follow-up:
- Revised plans were sent to Sharon Espina and Craig Oswald 21 February 2014
 - The test and fit is in great shape. Multiple conversations and e-mail correspondence have occurred with Sharon and Craig off-line since the Minneapolis Charrette.
- 1.5 Brooksville Test and Fit Follow-up:
- The test and fit is also in good shape. Multiple conversations and e-mail correspondence have occurred with Dr. Denietolis off-line since the Minneapolis Charrette.
 - Dr. Denietolis added she has a few minor edits, but is overall pleased with the plan
- 1.6 Rapid City Test and Fit Follow-up:
- Revised plans were sent to the Rapid City representatives for review and a conference call was held on 24 February 2014
 - Despite the direction the design was given during the Minneapolis Charrette, one of the major concerns with the layout is the bank of exam rooms that do not have double access to the rooms, nor do they have a central team work area
 - Tracy stated the plan revisions were underway to include a third PACT module for the integrated specialty services for this specific clinic
 - Dr. Denietolis reiterates the purpose of having the double access exam rooms in a primary care setting is directly related to the multiple teamlet staff that goes in and out of the room. The flow for specialty services is different, and does not have the same number of staff members accessing the room during a single patient encounter
 - A follow-up call to discuss the latest plan revisions has been scheduled for 25 February 2014
- 1.7 Nancy questioned to what extent the Modular Construction component of this project will be included in the next submittal:
- Tracy stated the development is ongoing and will be further refined based on the direction that Jay gave to Emily Dickinson during the Minneapolis Charrette
 - Jay expressed his dissatisfaction and disappointment with the Modular Construction section included in the deliverables to date.
 - He stated the design team has missed the intent of integrating principles of modular design integration through the design process of the prototype
 - Jay stated submitting additional work on the section is too late at a Pre-Final submittal
 - He also stated that including a placeholder is not acceptable at this stage of the project
 - Tracy responded that she would try to send a draft out prior to the Pre-Final submittal being issued to incorporate his comments.
- 2.0 Next Steps:
- Meeting with Rapid City representatives is scheduled for 25 February 2014 to discuss the revised layout
 - The Pre-Final Submittal will be published on 7 March 2014. Gabryela will be sending all meeting attendees throughout the course of this project a link via the SharePoint site to download the submittal for review.
 - The upcoming Final Presentation will be held at SmithGroupJJR's office in Washington DC. An agenda will be provided at the bi-weekly call on 11 March 2014
 - The bi-weekly call on 25 March has been cancelled since it coincides with the Final Presentation

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	4 March 2014
Meeting Date	25 February 2014
Location	Teleconference
Purpose	Discussion of Typical Exam Room Layout

PARTICIPANT	COMPANY	PHONE	EMAIL
Dr. Angela Denietolis	James A. Haley Veteran's Hospital, ACOS Ambulatory Care	813-972-2000 ext. 6209	Angela.denietolis@va.gov
Linda Chan	VACO CFM, Planner/Architect	202-632-4781	Linda.chan@va.gov
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Ashley Andersen	SmithGroupJJR, Architect I	202-974-4516	ashley.andersen@smithgroupjir.com

ITEM DISCUSSION ACTION
25 February 2014

1.0 Discussion of Typical Exam Room Layout

Attendees: Dr. Denietolis, Linda Chan, Tracy Bond and Ashley Anderson

- 1.1 Tracy Bond opened the discussion by explaining the design team has put together two layouts for typical exam rooms based on the feedback received so far and the goal of the meeting is to get the preferred configuration resolved today for inclusion in the prototype and test and fit layouts.
- 1.2 Glove Dispenser placement:
 - Dr. Denietolis explained that when using systems furniture, the glove dispenser would be built-in
- 1.3 Door location – Diagonal versus aligned doors:
 - Dr. Denietolis stated that most people will prefer option 1A which shows diagonal doors, but she prefers that the location of the sink and the doors be swapped
 - Dr. Denietolis is a strong proponent of the diagonal door configuration and believes that it works better with the layout of the room
 - However, Jay Sztuk is in the process of determining what the requirements are for the door swing and it may be mandated that the door open so that the exam table is behind the door for patient privacy reasons
 - In the Primary Care Annex, this was a requirement that the doors open this way, but they also have curtains over the doors that are considered a back-up system
 - Tracy asked whether for the prototype, the design team should show a sliding door on the staff side or a regular swing door.
 - Dr. Denietolis prefers to show a sliding door, but admits that the group as a whole seems to be divided on the issue, so she hesitates to completely get rid of the other option
 - Tracy stated for the prototypes, the design team will show diagonal doors with one sliding door on the staff corridor side. The project book narrative will discuss both options

- Dr. Denietolis agreed and reiterated that the option 1A should stay the same and that option 2A should be the same as option 1A except that the door and the sink will be flipped
 - The women's health layout should be more similar to option 2A
 - All doors in the plans should show the patient privacy swing and a diagonal configuration
- Dr. Denietolis pointed out that consult rooms should have the same door configuration as the typical exam room
- Tracy questioned whether the door should mimic the staff side or the patient side and suggests that the design team create a sketch for both to discuss in the final review meeting

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE ASHLEY ANDERSEN AT 202-974-4516 ashley.andersen@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

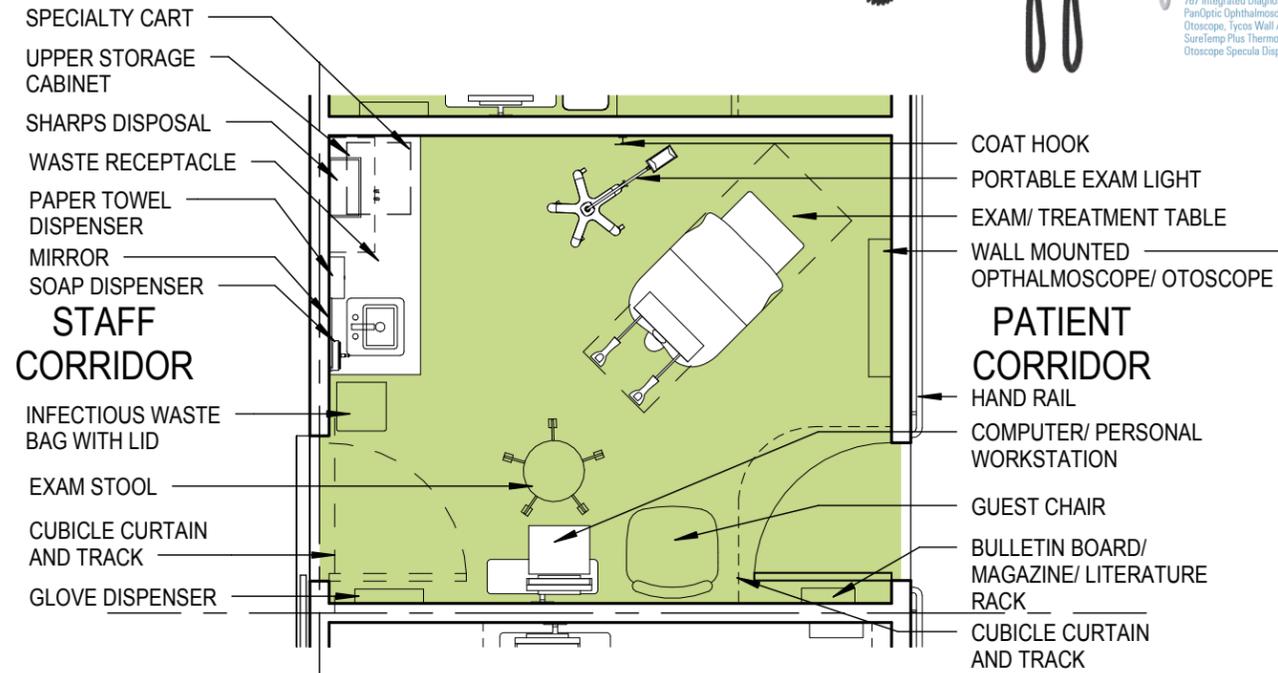
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767 Integrated Wall Systems 19

EYE, EAR, NOSE AND THROAT

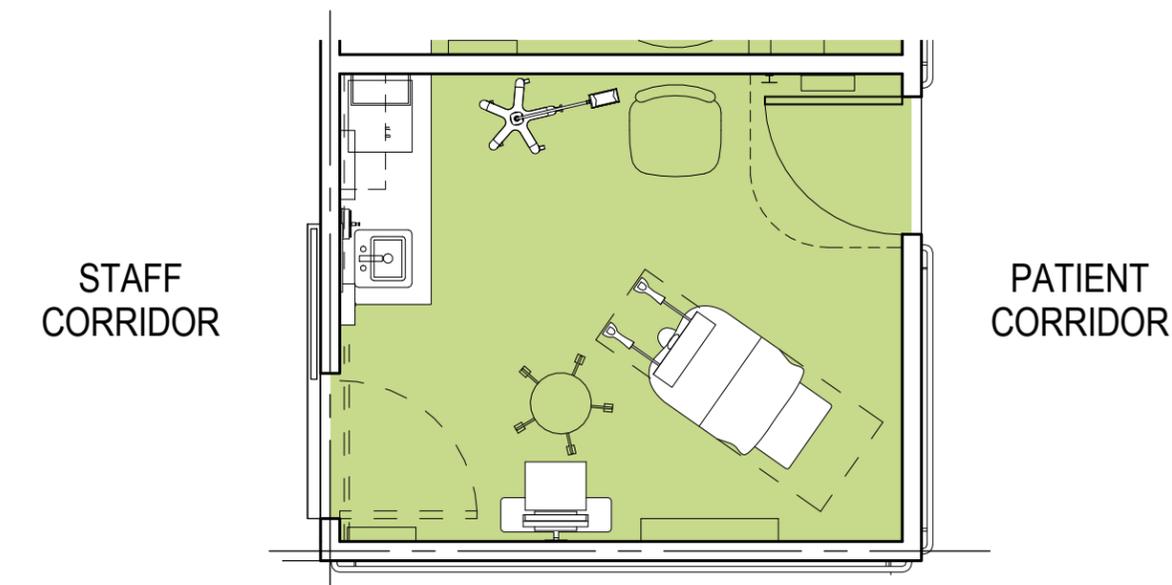


76791-2MPX
767 Integrated Diagnostic System with
PantOptic Ophthalmoscope, MacroView
Otoscope, Iyasa Wall Aneroid
SureTemp Plus Thermometer and
Otoscope Specula Dispenser



EXAM OPTION 1A

SCALE: 1/4" = 1'-0"

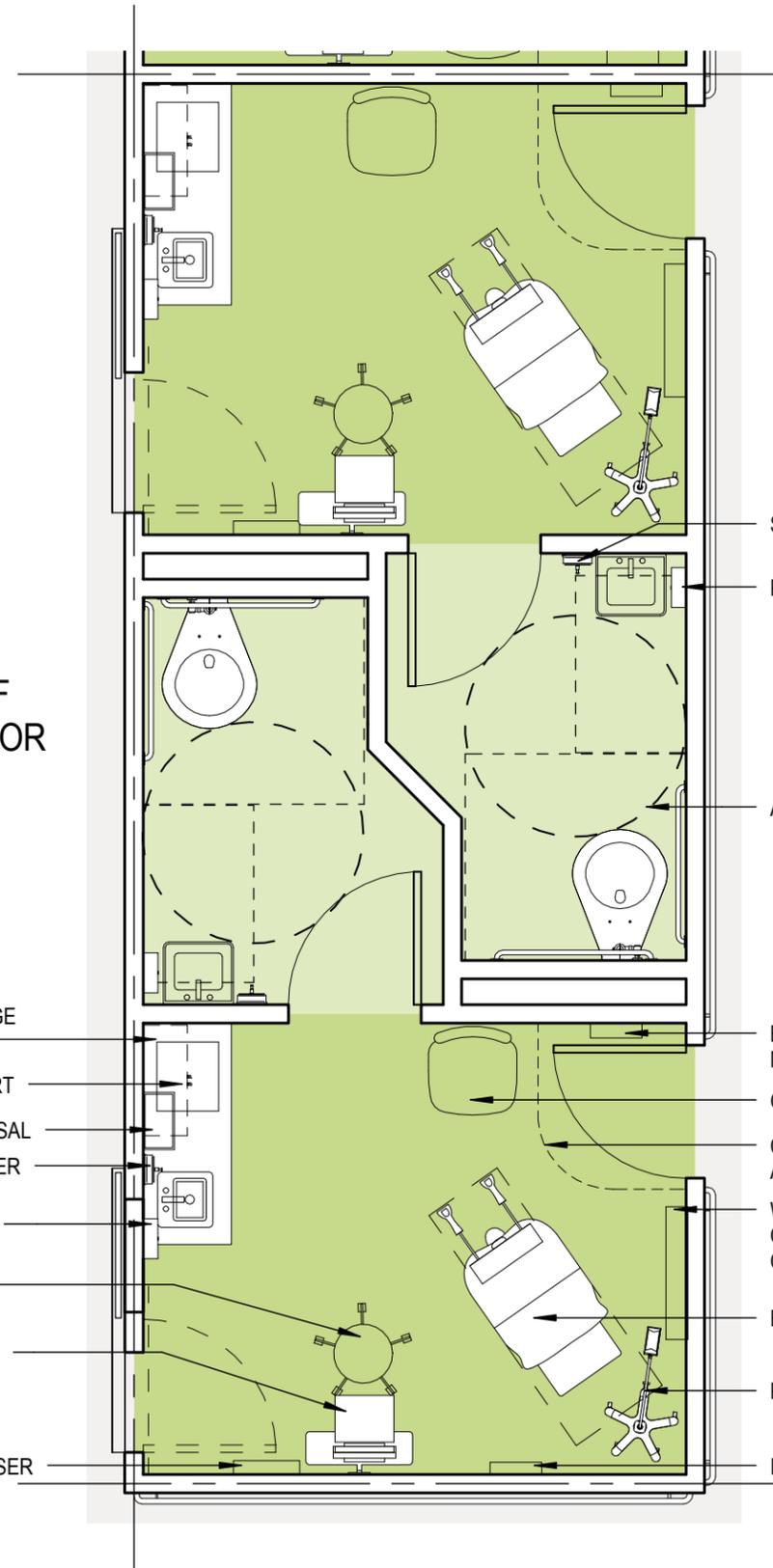


EXAM OPTION 2A

SCALE: 1/4" = 1'-0"

**STAFF
CORRIDOR**

- UPPER STORAGE CABINET
- SPECIALTY CART
- SHARPS DISPOSAL
- SOAP DISPENSER
- PAPER TOWEL DISPENSER
- EXAM STOOL
- COMPUTER WORK STATION
- GLOVE DISPENSER



TYPICAL WOMEN'S HEALTH ROOMS

SCALE: 1/4" = 1'-0"

- SOAP DISPENSER
- PAPER TOWEL DISPENSER
- PATIENT CORRIDOR
- ADA TURNING RADIUS
- BULLETIN BOARD/MAGAZINE RACK
- GUEST CHAIR
- CUBICLE CURTAIN AND TRACK
- WALL MOUNTED OPHTHALMOSCOPE/ OTOSCOPE
- EXAM/ TREATMENT TABLE
- PORTABLE EXAM LIGHT
- ILLUMINATOR

**TYPICAL EXAM
ROOM AND
WOMEN'S HEALTH
ROOMS**

DRAWING TITLE

ISSUED WITH

DRAWING REFERENCE

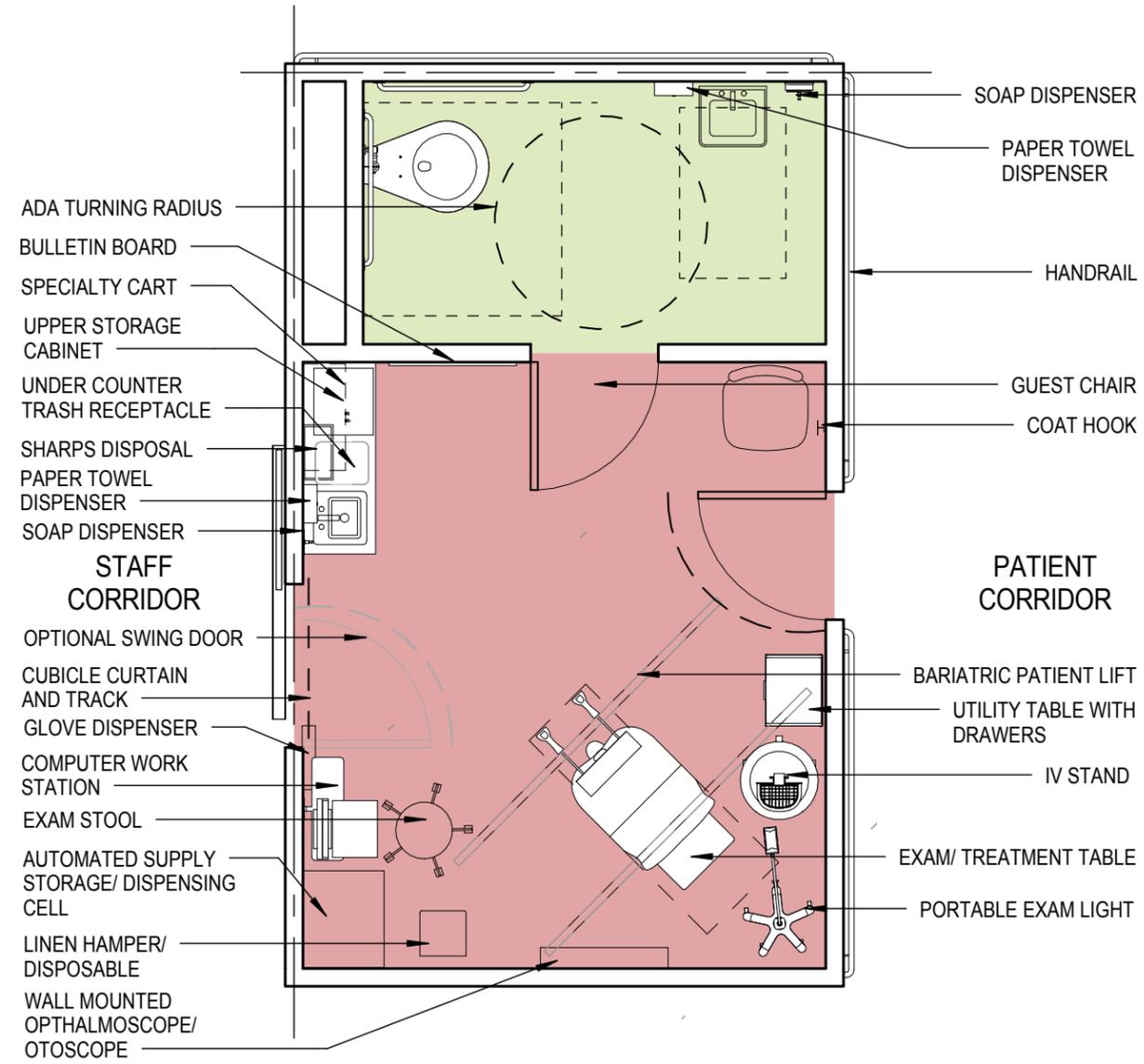
1/4" = 1'-0"
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01/09/14
DATE

VA CBOC SMALL
PROJECT NAME

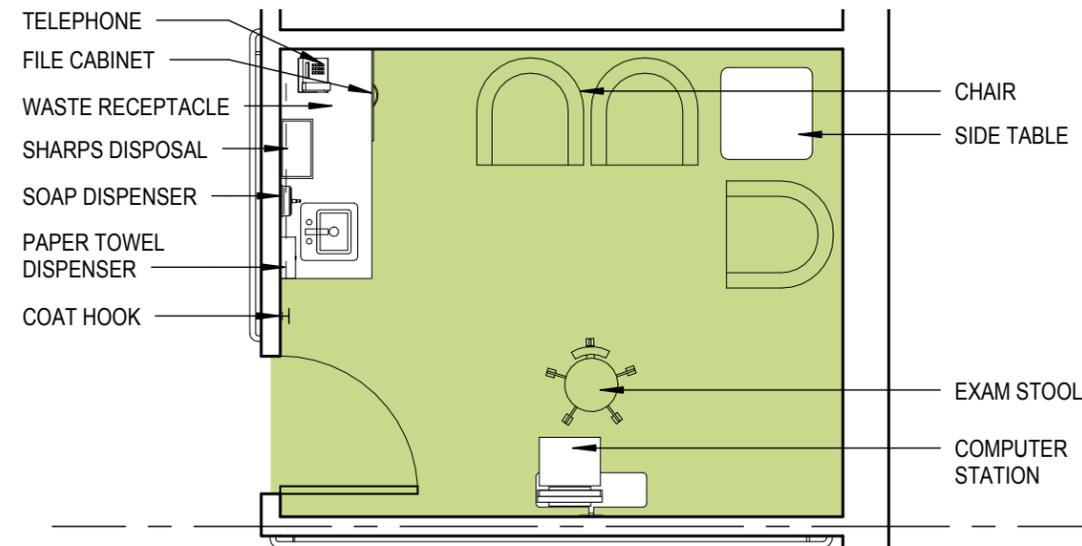
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DRAWING NUMBER



TYPICAL PROCEDURE ROOM

SCALE: 1/4" = 1'-0"



TYPICAL CONSULT

SCALE: 1/4" = 1'-0"

TYPICAL PROCEDURE AND CONSULT ROOMS

DRAWING TITLE

ISSUED WITH

DRAWING REFERENCE

1/4" = 1'-0"
 DRAWING SCALE

01/09/14
 DATE

VA CBOC SMALL
 PROJECT NAME

[28319.000]
 PROJECT NUMBER

E201
 DRAWING NUMBER

PROJECT: 28319 **VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities**

Date: 4 March 2014
 Meeting Date: 26 February 2014
 Location: Teleconference
 Purpose: Discussion Women’s Health Exam Room Layout

PARTICIPANT	COMPANY	PHONE	EMAIL
Dr. Angela Denietolis	James A. Haley Veteran’s Hospital, ACOS Ambulatory Care	813-972-2000 ext. 6209	Angela.denietolis@va.gov
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Ashley Andersen	SmithGroupJJR, Architect I	202-842-2100	ashley.andersen@smithgroupjjr.com
Chris Phillips	The Innova Group, Medical Equipment Planner		

ITEM	DISCUSSION	ACTION
	26 February 2014	
1.0	Discussion Women’s Health Exam Room Layout <i>Attendees: Refer to list above</i>	
1.1	Tracy bond gave a brief overview of the previous day’s call regarding the typical exam room layout <ul style="list-style-type: none"> Samina Iqbal explained the otoscope should be near the head of the exam table and that it typically is on the right 	
1.2	There were several observations made by the group during the tour in Paolo Alto: <ul style="list-style-type: none"> The group did not like the aligned doors and prefer that doors be offset, or diagonal in exam rooms as shown in the current women’s health layout There were concerns with sound, especially due to the doors that lead directly to the teaming area – the group wondered how this issue could be dealt with Tracy explained that sound issues can be dealt with in different ways and that some of these include materials that act as sound absorbers Tracy stated swing doors are generally more effective at mediating noise, but sliding doors have gotten better and will likely continue to become more effective in this area Samina Iqbal questioned if the staff area has high ceilings and skylights and if so, wouldn’t controlling the noise be more difficult? <ul style="list-style-type: none"> Tracy explains that even with these design features, the noise can be mitigated using the methods she previously described and added that in this scenario, the wall type and the door between the two spaces is particularly important Gary Fischer explained that concurrent with this project, a design guide is being developed to help inform the architects of these future clinics of what the requirements are 	
1.4	Peggy Mikelonis provided feedback on the Women’s Health Exam Room Layout: <ul style="list-style-type: none"> She emphasized the importance of the sound barrier, especially in the women’s health setting <ul style="list-style-type: none"> Dr. Angela Denietolis expressed while high-end barn doors may work well to mitigate noise, her concern is VA often ends up taking the lowest bidder at the time 	

of construction and those specifications become overlooked

- Need to provide solution for soiled linen; due to the amount of equipment needed in the room, Peggy Mikelonis feels that at least one sliding door is necessary in order to have adequate space in the room
- Cannot have clean and dirty items on the same cart at any time
- Auditory privacy is a concern; patients should not be able to hear conversations that occur in the staff area as they may be discussing private patient information
- The cart will not always be under the counter in the exam room – consider the space that takes up in other areas of the room

Samina Iqbal stated there aren't always dedicated women's health rooms in the CBOCs

- Dr. Denietolis and Gary explained the intent moving forward and in this prototype study, is to have dedicated women's health exam rooms

Samina Iqbal suggested that women's health should be located at the back of the clinic:

- Dr. Denietolis explained during the Minneapolis charrette, the group decided that the women's health rooms should be located at the front of the clinic instead
 - Due to the universal designed, and the flexibility of the PACT module, this can be easily adapted to suit the preferences of the individual clinics at time of design

Peggy Mikelonis explained there needs to be some exam tables that can be lowered to wheel chair height for self-transfer

- Tracy explained that in the prototype, all exam tables can fold into bariatric chairs and that there is a bariatric lift in the procedure room
- Peggy Mikelonis stated that all exam rooms should have lifts
 - Dr. Denietolis explains that the lift is only in the procedure room in the prototype
 - Chris Phillips says that he will check to see what is typically done with the lifts

Samina Iqbal asked why there is no scale shown in the exam room

- Dr. Denietolis explained that there is a height and weight station in the prototype and the scale has been removed from the typical exam room layout to reduce clutter

Gary closed the discussion by asking the group what is preferred between exam layout option 1A and option 1B

- Peggy Mikelonis prefers diagonal doors and a slider on the staff side, but reemphasized the noise is a major concern and should not be overlooked

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE ASHLEY ANDERSEN AT 202-974-4516 ashley.andersen@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.

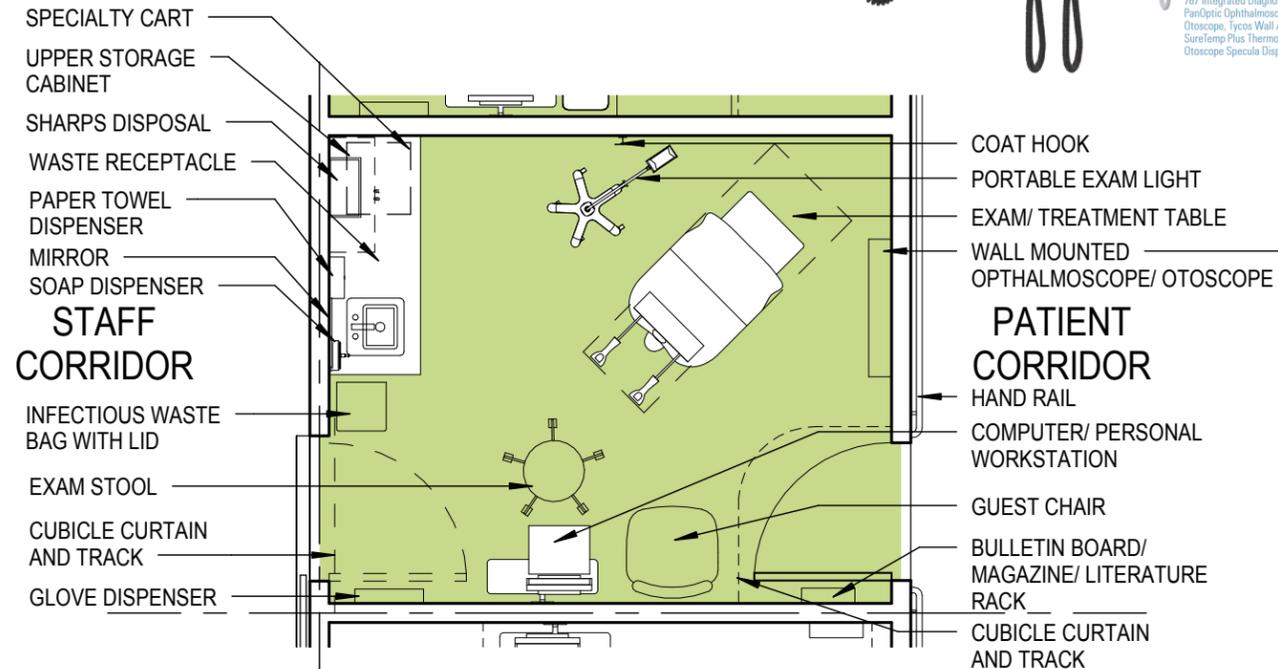
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EYE, EAR, NOSE AND THROAT



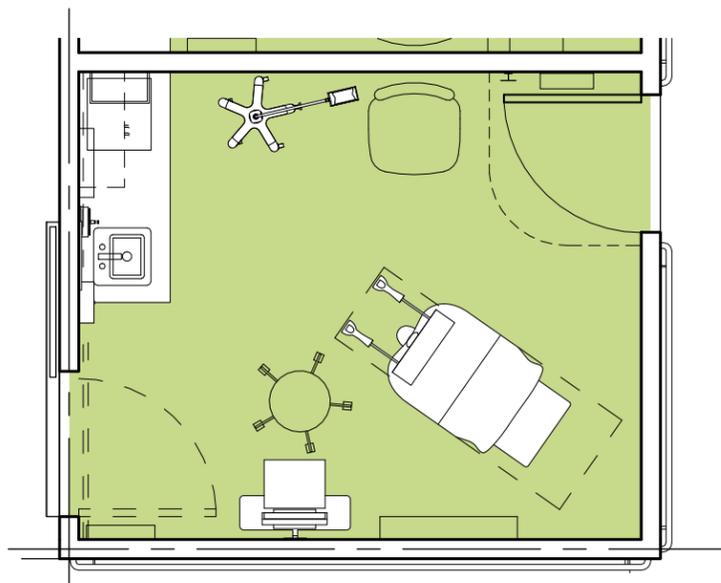
76791-2MPX
767 Integrated Diagnostic System with
PantOptic Ophthalmoscope, MacroView
Otoscope, Iyasa Wall Aneroid
SureTemp Plus Thermometer and
Otoscope Specula Dispenser



EXAM OPTION 1A

SCALE: 1/4" = 1'-0"

STAFF CORRIDOR

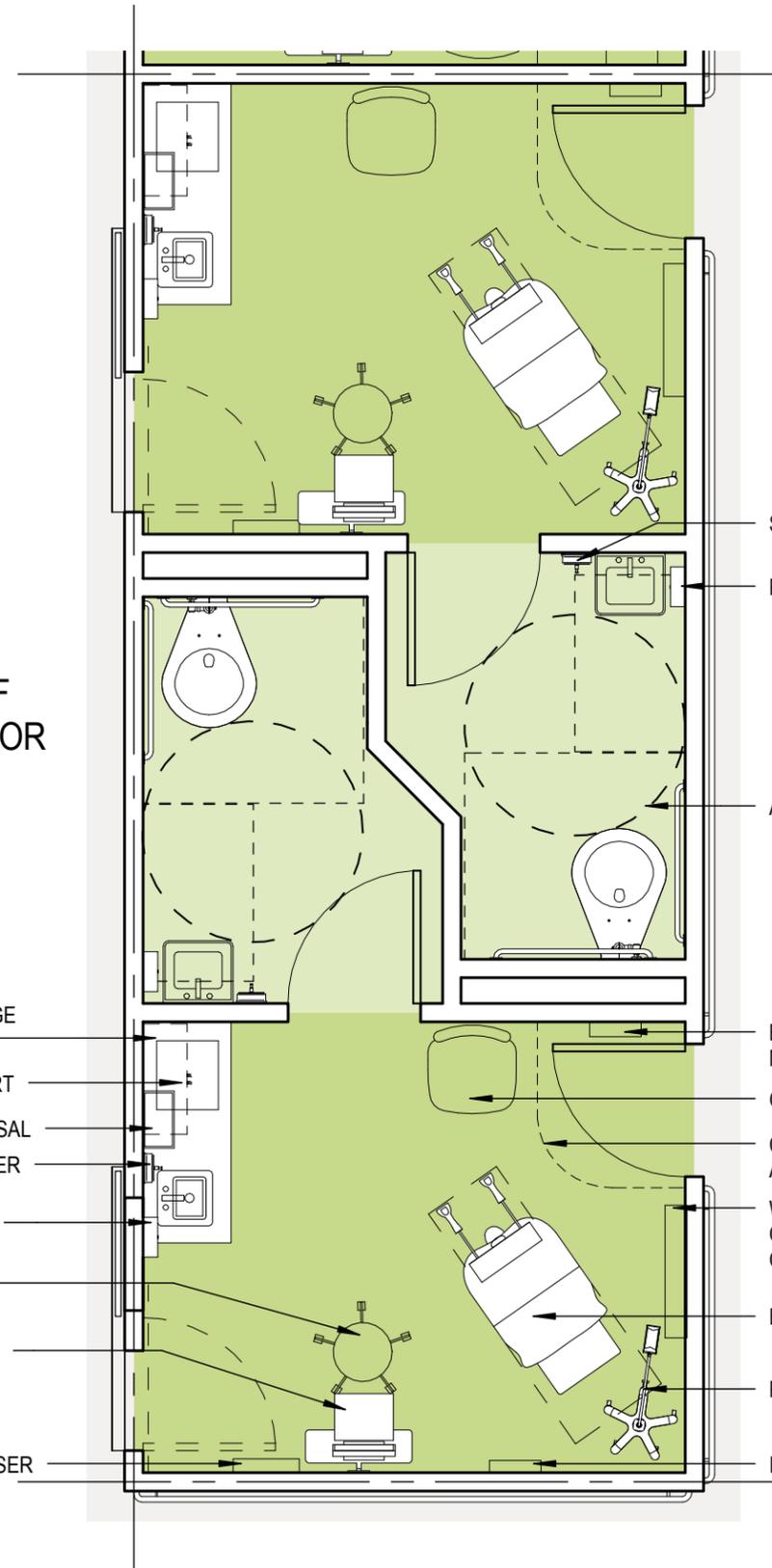


EXAM OPTION 2A

SCALE: 1/4" = 1'-0"

STAFF CORRIDOR

- UPPER STORAGE CABINET
- SPECIALTY CART
- SHARPS DISPOSAL
- SOAP DISPENSER
- PAPER TOWEL DISPENSER
- EXAM STOOL
- COMPUTER WORK STATION
- GLOVE DISPENSER



TYPICAL WOMEN'S HEALTH ROOMS

SCALE: 1/4" = 1'-0"

TYPICAL EXAM ROOM AND WOMEN'S HEALTH ROOMS

DRAWING TITLE

ISSUED WITH

DRAWING REFERENCE

1/4" = 1'-0"
DRAWING SCALE

01/09/14
DATE

VA CBOC SMALL
PROJECT NAME

[28319.000]
PROJECT NUMBER

E200
DRAWING NUMBER

PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	5 March 2014
Meeting Date	28 February 2014
Location	Teleconference
Purpose	Rapid City Test-fit Revisions Follow-up

PARTICIPANT	COMPANY	PHONE	EMAIL
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Steve Zerhusen	Real Property/ VACO	202-578-7521	Steve.zerhusen@va.gov
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Dave Treece	SmithGroupJJR, Architect/Senior Medical Planner	202-842-2100	Dave.treece@smithgroupjjr.com

ITEM DISCUSSION ACTION

1.0 Test Fit Comments – teleconference

1.1 Overall introductions were made for the various locations.

1.2 PACT MODULES

Dave Treece reviewed the revisions based on a 3 PACT model, maximizing the number of exam and consult rooms with two doors.

- Each PACT module teaming has an interconnecting corridor.
- The Rapid City PFD has 57 exam, consults, procedure and other patient encounter rooms.
- The revised layout has 58.
- The PFD does not have women’s health exam rooms, in the test fit, the rooms with adjoining toilets are labeled exam.
- Layout also has two procedure rooms with adjoining toilets.
- Cast room and Scope washer are located to the far right end of the modules

1.3 Conference Room

- The revision also includes a bank a three conference rooms, when combined will provide approximately 1300 sf for the BHHCS staff meetings.
- Dave T noted that the request was for 1500 sf, C.B. stated that 1300 will be satisfactory to meet the ends.

1.4 Wheelchair storage

- The entry vestibule will be revised to have the storage accessed from the lobby area and not from the entry vestibule.
- The concern is that these will not be parked in the proper location and may cause congestion within the entry vestibule.

1.5 Registration

- C.B. had noted in an earlier email, a concern about the registration.
- Dave T discussed that the revised registration has the ability to have 8 positions – 6 in the

front and two on the side for this process.

1.6 Other departmental modules.

- OIT is a unique element from other prototypes, and the test fit will keep the larger program space.
- AMMS incorporates the large module and increases the storage room
- EMS includes the requirements for showers
- Business offices are included based on discussions from the Minneapolis workshop.
 - (Business offices are in the Rapid City PFD)
- Laboratory uses the large prototype.
 - Rapid City to confirm the COAG and Chemistry areas.
- Imaging uses the large prototype, deletes the mammography and includes Pulmonary function.
- Dental uses the large module
- Prosthetics is included based on the large prototype, currently not in the PFD.
- Pharmacy is based on the large and increased the intake area from 2 to 3.
- Audiology is based on the minimal requirement for this department based on the discussions from the Tampa workshop discussion with the subject matter experts.
 - Dave T noted that there are 4 additional exam rooms on this corridor.
 - Dr Koopmeiners stated that the 4 extra rooms could meet the needs of tele-audiology. These rooms will be labeled exam rooms.

1.7 Building area take off

- Dave T noted the overall Building Gross is 65,612
- The PFD BGSF is currently at 65,891 (not all programs have been updated)
- First take off for rentable is approximately 45, 925
- Dave T noted the design team will review this take off to be sure everything is included.

1.8 Other Comments

- John H wanted to be sure the plan reflects the typical door layouts based on the prototype.
- Dave T will revise the test fit to match the prototype.
- Each participant was asked for any further comments, all stated they are good to go for this test fit.

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE DAVE TREECE AT 202-974-0832 dave.treece@smithgroupjjr.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.



END OF MINUTES

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 28 March 2014
 Meeting Date 25 March 2014
 Location SmithGroupJJR Office, Washington DC
 Purpose VA CBOC Final Presentation

PARTICIPANT	COMPANY	PHONE	EMAIL
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Peter Yakowicz	VISN 23 Capital Asset Manager	651-405-5633	Peter.yakowicz@va.gov
Steve DiStacio	VA Black Hills	605-720-7170	Stephen.distacio@va.gov
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Tracy Bond	SmithGroupJJR, Project Manager/Architect/Medical Planner	202-974-5161	tracy.bond@smithgroupjjr.com
Gabryela Passeto	SmithGroupJJR, Architect	202-974-0830	gabryela.passeto@smithgroupjjr.com
Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	chris.phillips@theinnovagroup.com

The following participated via tele-conference

Don Myers	CFM, Director, Facilities Standards Service	xxx-xxx-xxxx	xxxxxxx@va.gov
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Timothy Bertuccio	VISN 21 Deputy Capital Asset Manager	707-562-8331	Timothy.bertuccio@va.gov
Sharon Espina	VA Kauai	808-246-0497	Sharon.Espina@va.gov
Sylvia Wallace	Chief Engineer, VA Canteen Services	314-845-1252	Sylvia.wallace@va.gov
Adam Darkins	Chief Consultant, Telehealth Services	202-461-6777	adam.darkins@va.gov
Orest Burdiak	CFM, Principal Interior Designer	202-632-4759	orest.burdiak@va.gov

ITEM	DISCUSSION	ACTION
	25 March 2014	
1.0	Final Presentation – Washington, DC	
	<i>Attendees: Refer to list above</i>	
1.1	The group is welcomed to Washington DC and introductions were made around the room. Gabryela begins with a Final Submittal Update. The key remaining date after this meeting in the Final Submittal on 31 March 2014. <ul style="list-style-type: none"> • Pre-Final Submittal issued on 7 March 2014 • One, Two and Three PACT CBOC Prototypes completed • Components and Ancillary Services Diagnostic Modules refined and completed • Test and Fit layouts for Maui, Brooksville and Rapid City completed • Off-site Construction Adaptations Methods + Impact • NSF to DGSF vs. NUSF (leased) Calculations 	

- 1.2 Gabryela reviews the Pre-Final Submittal Review Comments Status with participants
- A comments template was created by SGJJR to facilitate the issuing and organization of review comments. The template was issued on 10 March 2014 with instructions on how to complete the form
 - Due to the fast project schedule, comments were due on 17 March 2014 in order to be incorporated in the Final Submittal, less than two weeks after the due date
 - All comments received by the due date have been processed
 - Additional comments were submitted after the due date and have not been processed yet
 - Jay suggested we discuss how these comments would be incorporated and possibly need to provide an extension to the Final Submittal to address all of the comments.
 - Gabryela explained that most of the comments are technical and grammatical versus content related comments. Comments presenting conflicting issues have been addressed with Jay as they arise and resolved off-stage
- 1.3 Components Overview: In the Pre-Final Submittal, graphically the outline of components on the overall prototype plans did not read well and were confusing. Graphically, these have been updated and presented to the group.
- In addition to the text leader with the component identified, Gabryela suggested adding text referring readers to Section 4, or the Figure number that corresponds with the component for additional information.
 - Vestibule/Entry:
 - Review Comments:
 - Direct air path – off set doors shown is too little to be effective
 - Location of wheelchairs – wall creates a narrow channel much longer than it needs to be and difficult to get in and out.
 - Discussion:
 - Layout has been revised to show off setting doors.
 - Jay stated the wheelchair alcove is not thought out. For the quantity of wheelchairs being stored, the space is inefficient and will create bottlenecks
 - The vestibule depth is too long. Advised to change it to 12'-0" depth to comply with LEED.
 - Dentistry:
 - Review Comments:
 - There are challenges in making a galley arrangement work for dental clinic
 - The design of the dental treatment rooms and head set orientation does not accommodate right/left handed providers equally
 - The design of the clinic offers little opportunity for natural light which is critical for proper tooth shade matching
 - Switching locations of the x-ray and clean room would place imaging closer to the dental treatment rooms which is preferable
 - Discussion:
 - The guidance given throughout the study was to make all rooms right handed. There is no way to determine what percentage of left handed providers would use the space.
 - Fred Webb stated tooth shading can be achieved using specialized lighting
 - The x-ray room is larger than your typical exam room, hence switching the clean cart room would disrupt the universality of the module.
 - Eye Clinic:
 - Review Comments:
 - Add Eye Clinic to One PACT CBOC
 - Discussion:
 - It was determined the Eye Clinic is not included in the ONE PACT CBOC. Instead, a component has been created should the clinic have the workload to support inclusion of the eye clinic.

2.0 NSF to DGSF vs. NUSF (Leased) Calculations

Chris Phillips begins the discussion defining the differences between NSF, DGSF and NUSF. These definitions came from a VA Standards Alert posted on the Technical Information Library (TIL) named "STANDARDIZATION OF SQUARE FOOTAGE SPACE DEFINITIONS AND MEASUREMENTS FOR VA FACILITIES" dated April 1, 2012.

- Net Square Feet (NSF)
 - The area of an individual room/space that is available for use by personnel, furnishings and equipment. NSF for each room or space is measure from the inside finished surface of surrounding permanent wall, excluding the area bounded by the outside finished surfaces of structural columns and shafts
- Department Gross Square Feet (DGSF)
 - Used for VA owned facilities, is a measurement of an assemblage of rooms and spaces as assigned to a department or service and includes internal departmental or service circulation of walls, columns and projections enclosing the structural elements of the building within the space. The boundary defining DGSF is drawn from the inside finish of the permanent exterior building walls to the rooms side finish of the building common areas or the centerline of department-separating wall partitions.
- Net Usable Square Feet (NUSF)
 - Used for VA leases is that portion of rentable space that is available for a tenant's personnel, furnishings, and equipment and includes the floor area of full-height columns and projections enclosing the structural elements of the building within the space. Net usable space is the area for which VA will pay a square foot rate.

2.1 Caitlin Cunningham said that she had not seen these before and that she uses the definition of NUSF from the Leased Based Outpatient Clinic Template SFO Appendix B dated May 2009. It was discussed that another meeting would be established with Real Property to ensure that we use the correct calculation method for NUSF in our documents.

3.0 Typical Equipment: Review Comments + Layout

3.1 A Vital Signs Monitor (M4116) will be added to each exam room with a preference of wall mounting with the Oto/Ophthalmoscope. The preferred Vital Signs Monitor has the ability to transmit data into the electronic health record, so wireless capability or a data jack needs to be provided.

3.2 A second computer will be added to all Dental Treatment Rooms for imaging purposes

3.3 Shared Medical Appointment Rooms and Group Rooms will have a two Workstations on Wheels (WOWs) each

4.0 Maui Test and Fit

4.1 HBPC Layout requires some reworking to accommodate additional storage space requirements. Tracy will resolve this off-stage with Sharon for the Final Submittal

- No other issues identified

5.0 Brooksville Test and Fit

- No issues identified
- New Brooksville PFD has not been received from Rita

6.0 Rapid City Test and Fit

- Review layout to adjust corridor width to 6'-0" throughout adjacent to Logistics.
- No other issues identified

7.0 Off-Site Construction Adaptation Methods + Impact

7.1 Tracy began the discussion providing an overview of the research done by the team about off-site modular construction. The team contacted 8 different manufacturers and established a matrix with transportation limitations, module size, types of structural systems and shipping capacity

7.2 One PACT Modular Option:

- 10'x5 ½" width to maintain the overall building as designed
- 19'-4" maximum span for intermediate 4" tube steel columns
- Group Room and Shared Medical Appointments would require an additional beam structure to be positioned on suite
- This option recommend the Lobby/Commons area be site built or utilizing panelized construction

7.3 One PACT Modular Option - Alternate:

- 10'x6" width grows the clinical module approx. 97 square feet
- 19'-4" maximum span for intermediate 4" tube steel columns
- Trusses to avoid columns in the middle of open spaces such as Group Rooms, Shared Medical Appointments and Team Work Area
- Vestibule is reduced to allow it to be a single module for shipping
- This option also recommends the Lobby/Commons area be site built or utilizing panelized construction, but the same truss system could be used

7.4 Two PACT Modular Option - Alternate:

- 10'x6" width grows the clinical module approx. 190 square feet
- 19'-4" maximum span for intermediate 4" tube steel columns
- Trusses to avoid columns in the middle of open spaces such as Group Rooms, Shared Medical Appointments and Team Work Area
- This option also recommends the Lobby/Commons area be site built or utilizing panelized construction, but the same truss system could be used

7.5 Structural Bay vs. Modular Bay

- The structural requirements are different between on-site construction methods and off-site construction. Modular construction has to adhere to the limitations transportation.
- If working with the structural bay, it would be divided into three modules.

7.6 Jay questioned why an option wasn't shown to maximize the most typical module width of 12'-0" as opposed to 10'-5 ½" or 10'-6" since the structural bay is obsolete once modular construction is used.

- Tracy explained those options were explored early on in the design phase and it presented multiple conflicts, such as structural supports in doorways or impacting the preferred equipment and furniture layouts of the rooms. This was also a challenge since the preferred door placement in the right-handed universal rooms, the doors into the room are located diagonally from each other.
- Jay stated these are the concerns that need to be noted, so that at the time of design, they know what issues to look for when making these decisions. Jay wants to understand what is compromised in the design when maximizing the module width occurs.

8.0 Next steps

8.1 Follow-up with Radiology to review their comments. Group believes it is a matter of clarifying the design intent

8.2 Follow-up meeting required with VA Real Property Service to understand how NUSF is calculated for inclusion on the drawings in the Final Submittal.

8.3 Jay requested a read-ahead of the Final Submittal prior to printing and distribution to VISNs to ensure all the comments were picked up. The purpose of the read-ahead is not to create new comments, but confirm issues from the 7 March 2014 Pre-Final Submittal were addressed.

- The Final Read-Ahead Submittal will be issued on 3 April 2014 to the Core Steering Group only
- A review meeting will be held 7 April 2014 to address any comments that were missed.
- The Final Submittal will be printed and published on 10 April 2014

END OF MINUTES



PROJECT: 28319 VA101F-13-J-0176:

Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date	25 March 2014
Location	SmithGroupJJR Office Washington DC
Purpose	Final Presentation

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PROJECT: 28319

VA101F-13-J-0176: Prototype Development and Standardized Design and Construction of Community Based Outpatient Clinic (CBOC) Facilities

Date 27 March 2014
 Meeting Date 27 March 2014
 Location Telcon
 Purpose Radiology Follow-Up

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Chris Phillips	The Innova Group, Medical Equipment Planner	512-346-8700	Chris.phillips@theinnovagroup.com

ITEM DISCUSSION ACTION

- 1.0 **Space Programming: Radiology – 1000 - 1100**
Attendees: Jay Sztuk, Dana Sullivan, Dr. Charles Anderson, Tracy Bond, Gabryela Passeto and Chris Phillips
- 1.1 Dr. Anderson and Dana Sullivan expressed concerns about the Radiology footprint in the CBOC Prototypes. Comments were issued from the Pre-Final Submittal dated 7 March 2014. Review comments were discussed for clarification and design intent.
- 1.2 Common reception area for all patients for all services. This might cause bottlenecks as each service has its own sign-in and processing procedures. This would need large enough to accommodate simultaneous patient arrivals for multiple different areas.
 - Tracy explained the reception is intended to be shared for all services in the Ancillary Services Diagnostic Module (ASDM).
- 1.3 Sub-waiting for patients and family members assisting patients:
 - Based on the original space programming meeting in January 2014, the understanding was that a sub-waiting was not required. Instead, patients would be queued in the dressing rooms provided immediately outside of the radiology rooms
 - The main waiting is close enough to the department where family members can still assist patients before and after their appointment, but during the appointment, the main waiting area is to be utilized
- 1.4 Break room/locker rooms/conference areas for Radiology Staff:
 - Staff support spaces such as break rooms/lounges, and conference areas are located along the bar side of the ASDM and is intended to be shared with other ancillary and diagnostic services
- 1.5 Mobile Technology Pad:
 - The layouts propose the mobile technology pad be located outside of the clinic, but adjacent to the radiology department. Although the mobile tech pad is not dedicated to radiology, it is likely the only the department that will utilize the service.
 - A separate entrance for radiology is not included as part of the prototype. All patients enter through the main vestibule, into the main waiting area and proceed to specific areas for their appointments
- 1.6 Air conditioning and adequate power for radiography rooms:
 - HVAC and electrical requirements are outside of the scope of work. At the time of design, loads and capacities will be calculated to ensure optimum utility needs

2.0 Discussion Outcome and Next Steps:

- 2.1 A stainless steel prep sink and countertop with wall cabinets will be provided outside of the Radiology Rooms

END OF MINUTES

IF THIS REPORT DOES NOT AGREE WITH YOUR RECORDS OR UNDERSTANDING OF THIS MEETING, OR IF THERE ARE ANY QUESTIONS, PLEASE ADVISE GABRYELA PASSETO AT 202-974-0830 gabryela.passeto@smithgroupjir.com WITHIN 5 BUSINESS DAYS; OTHERWISE MINUTES WILL STAND AS WRITTEN.