# MEMORANDUM

**MEMO DATE:** October 3, 2016
**REVISION DATE:** Date

**PROJECT NAME**:UHS Wilsonville Behavioral Health Hospital **SRG PROJECT #**: 215005

**TO**: Pamela Brink, Project Manager
UHS of Delaware

**FROM**:Jon Mehlschau, AIA

**SUBJECT**: Response to OHA CON Comments **DISTRIBUTION**:

**ATTACHMENTS**: Patient Type Plans, Patient Window Sightline Diagram, Patient Schedule,

SRG

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In response to the comments received on 9/29/2016 from the Oregon Health Authority regarding the CON resubmittal on the Facility Design and Construction review, we offer the following information:

**1. As we review your plans it is not clear how, as required by OAR 333-535- 0061(8)(d), child and adolescent care units are physically and visually separate from each other and from adult units. It does not appear that, without alterations to the plans, this requirement can be met.**

Response: The proposed design has been revised to clearly indicate the separations between the age groups on a per Unit basis. Unit 2A has been identified for Adolescents, the Geriatric Unit has moved to 2B, and Units 1A/1B is identified for Adults. UHS has elected to not have a Child age patient component, and Unit 2A would be unique for Adolescents, and the separate scheduling of Activity Yard #2, and the other shared support spaces like the Gym, and Dining, would maintain the separation between the patient age groups, see attached Patient Schedule.

**2. Although you have designated Unit 2A as a 24-bed geriatric unit, the rest of the patient rooms are not labeled for the age population to be served in them. In order to establish need for the project, your application posits serving 20 child/adolescent patients, 60 adult patients and 20 geriatric patients. Given the design of the facility, it does not appear to us that it could successfully serve this patient mix.**

Response: To meet the proposed patient mix, the units would be assigned as follows (see attached patient type plans); Unit 1A & 1B, 52 adult beds; Unit 2A, 24 adolescent beds; and Unit 2B, 24 geriatric beds. Initial projections for bed allocations did not align well with the design given the site parameters and land requirements and as such we had to modify our design slightly to better accommodate the actual space we are intending to build. Actual utilization within these units will vary with the assignment of single occupant rooms depending on behavior and treatment protocols. The four units will share support facilities like the dining by scheduling separate times. See attached Patient Schedule.

**3. Although your June 28, 2016 response references "window treatments" and "glass frosting", patient rooms must have visually functional windows as outlined in OAR 333-535-0025(1)(c). As presented, it does not appear that required visual separation will be achieved in the patient activity yards and at the nursing stations**.

Response: The proposed windows in the patient rooms meet the referenced OAR, which requires 16 sf minimum of windows in each room, of which 8 sf is required to be viewable from the patient bed. The WVBH project has 24 sf of windows in each room, with the lower half obscured with a frosted interlayer, leaving 12 sf of windows on the upper half viewable.

Regarding OAR 333-535-0061(8)(d): Visual separation meeting this OAR is achieved with the walls and doors at the nurse station, and by the patient room windows not providing a line of sight into the patient activity yard due to the use of obscured glass. The adolescent unit specifically shares a patient activity yard with the geriatric unit because that unit is unlikely to climb up to the viewable portion of the window, see attached patient window sightline diagram.

**4. As we previously noted in our letter dated April 26, 2016, OAR 333-535- 0061(8)(a) requires that the environment of child and adolescent units reflect the age, social and developmental needs of children and adolescents, including spaces to accommodate family and other caregivers. Consequently, the environment for children and adolescents will differ from each other and will not be the same environment required for adults and geriatric patients. How will the shared seclusion, social work and exam rooms be made age appropriate? Without the requested "detailed functional description" cited above, it is not possible to see how the single dining room will adequately accommodate the needs of four different shifts for each meal three times a day. In addition, access to the single gym also seems problematic given the design of the facility.**

Response: The adolescent unit will have an appropriate environment for their age that is different from the adult and geriatric units. The furniture will be different in its form, color, and upholstery patterns. The wall paint will be different in color, and the use of graphics will be different. The social work room is a staff only space, a seclusion room and exam room has now been identified for adolescent use, and the adolescent unit will not have shower curtains. The overall intent is to have a friendly and nonthreatening environment where adolescents feels safe. A bright contemporary feel would work for all age groups which would unite the facility. The adult and geriatric units would also have a contemporary feel that is timeless (doesn't go out of fashion) with the same intent to be friendly, nonthreatening, and safe.

All age groups will want to be uplifted by the interior design, so there will be some commonalities across the facility to avoid looking like you've passed from one world to another. This is why the shared support spaces will be successful, they will have some commonalities in the appearance to bridge all the age groups. The primary difference between all the age groups will be in their furnishings, bedding, activities, engagements, and therapies.

Family and caregiver visitation would typically occur in the dining area, and if visitation occurs on the unit the activities rooms would be used. See attached Patient Schedule for when these spaces are accessed.

**5. OAR 333-535-0061 (7)(a) requires that five seclusion rooms be provided but we only see four.**

Response: This OAR requires 1 seclusion room for every 24 beds, which for a 100 bed facility is 4.167 seclusion rooms. Rounding up significantly requires the 5 seclusion rooms. The proposed design has been revised to provide the 5th seclusion room as part of Unit 1. See attached updated floor plan.

**END OF MEMORANDUM**