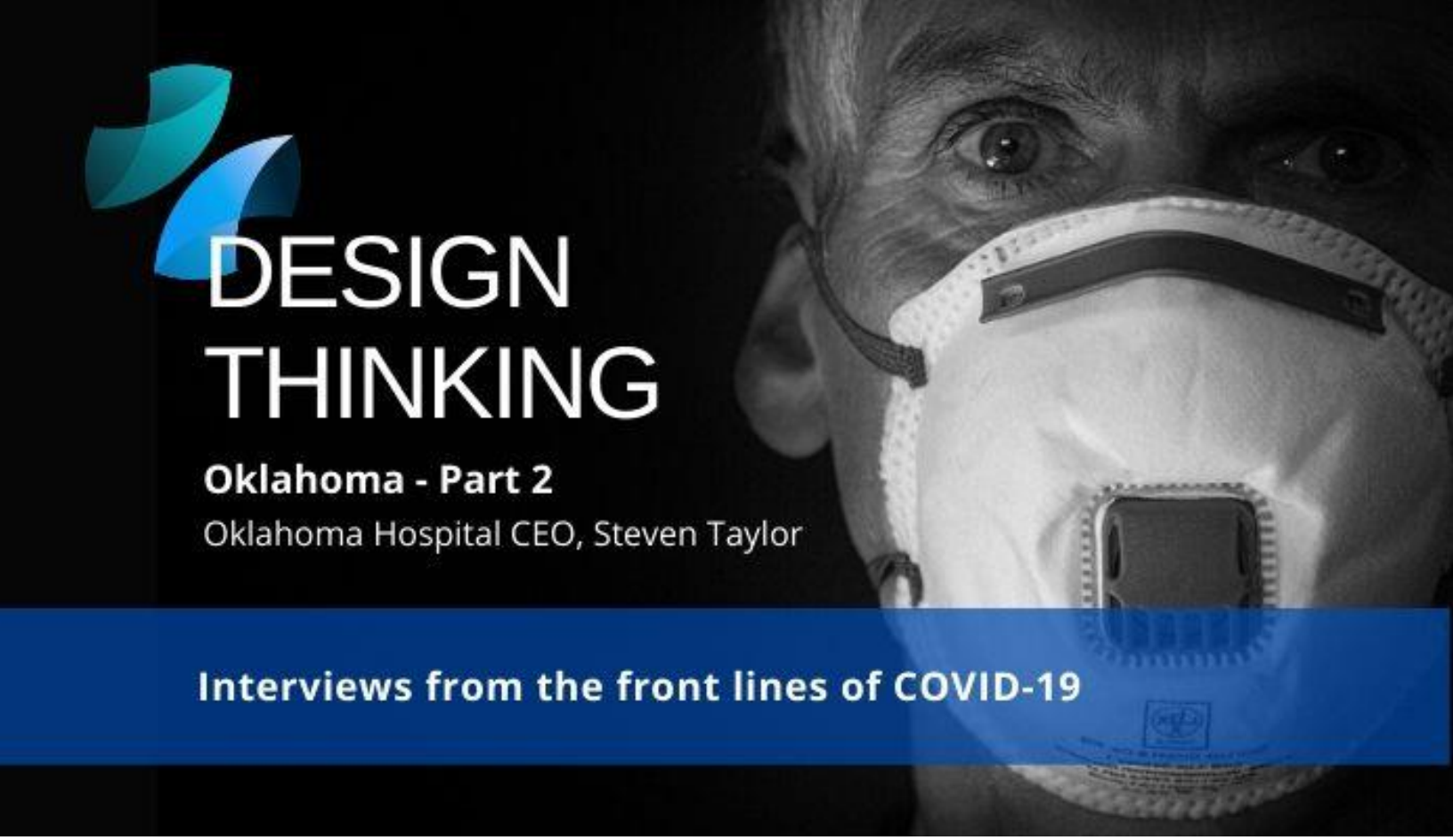

HFG architecture

Design Thinking Interview

Steven Taylor - Oklahoma
Regional VP of Stillwater Medical Center (SMC)
CEO of Blackwell and Perry Hospitals

Over the past several weeks, we have been collecting lessons learned and now wish to share these in a weekly series, *Design Thinking: Interviews from the Front Lines of COVID-19.*

We launched this series with our interview of Steven Friedman, PE, Facility Director at Memorial Sloan Kettering Cancer Center in New York City. Mr. Friedman was a principal consultant on the conversion of the Javits Center to a temporary medical facility. His insight and knowledge were particularly timely as both the federal and state governments were contemplating these type projects in Arkansas, Nebraska, Kansas, Oklahoma, and Missouri.

As our discussions with other hospital and healthcare officials have continued, we've learned that as COVID-19 has placed unique stress on our healthcare system, hospital teams have found ways to evolve and adapt patient treatment and care, staffing, supply chains, patient flow, equipment planning, telehealth, infrastructure, and master planning.

Response to COVID-19
Oklahoma CEO, Steven Taylor

Dwayne Robinett, Director of HFG Architecture's Oklahoma operations, recently spoke with hospital CEO, Steven Taylor, about his response experience to
COVID-19. Steven is a Regional VP for Stillwater Medical Center and CEO of Blackwell Hospital and Perry Hospital.

1. **How has COVID-19 impacted normal operations of your facilities' staffing patterns, training, and maintenance?**

   For smaller hospitals, having a constant high census and working with isolation patients is unusual. This reinforces the need for ongoing training, like PPE (Personal Protective Equipment) fittings, and checking batteries more regularly for the equipment needed to support that. Facilities may need to think outside the box on patient to staff ratios and be creative. There may be things nurses do now that others could do to free up nurses to help more patients. At larger facilities there is more staff overall, so it is easier to shift staffing to areas of need and that staff has probably done more high-census work and is ready for it.

2. **What is the one thing you have learned from this pandemic and hope to improve from as you move into the future? (what insight can you gain as you plan for the future?)**

   The supply chain is currently dependent on "just-in-time" inventory which increases difficulty finding adequate supplies during these types of events. That made it difficult to find supplies (personal protective equipment, or PPE, respirators, etc.) during the pandemic since everyone is in the same situation, including foreign countries, many of whom manufacture PPE and need the supplies for themselves. SMC ended up finding a lot of their own PPE through current vendor relationships and local businesses. Nobody was prepared for this shortage, and nobody knows if we will need to prepare like this again.

3. **What are your expectations for the future of healthcare design directly resulting from this pandemic?**

   Even though droplet precautions have shown to be effective, it is important to protect staff as much as possible and help to provide staff confidence that they are being protected as much as possible. This may lead to more negative air zones implemented across hospitals. It makes you think. Since you have to have decontamination areas anyway (like at the ED), could you utilize that like triage for a potential entrance for a COVID or other future issue instead of front door? Are there other things we can do to reduce the need to stock as much PPE? Probably, but the need will always be there because of the nurse/patient or doctor/patient interaction, especially in ICU's (Intensive Care Units).

4. **Do you think people will view healthcare differently going forward? How will healthcare delivery methods change?**

   People see hospitals as a place where they should be able to go to get anything done (i.e. COVID testing, treatment, etc.). That may not always be the case. The public now realizes hospitals won't necessarily always have all the supplies they need in these situations. We will apply what we've learned from this and will be better prepared in the future, but you can't always solve for the "what if" and unknown. Good plans today could change tomorrow. That's okay. We're all still learning.

5. **What will you do now to prepare for another potential future outbreak?**

   Communication, even between staff and different departments, can be challenging. In general, I believe you cannot overcommunicate, and certainly in this situation. No matter how much, it still isn't enough. We should learn from this and figure out how we can communicate better and faster in the future.

6. **Were there specific practices or facility advantages that allowed your hospitals to quickly adapt to treating COVID-19 patients? What were the barriers that hindered necessary changes?**

   Increasing isolation room capacity would be easier if patient room windows that can be partially opened or modified to open near fully would allow for easier conversion to negative pressure rooms using portable units. Security systems that were in place provided for easier lockdown of the facility to direct everyone to minimal locations for screening and restricting visitors. In trying to increase ICU capacity, current acute care rooms did not have all the medical gases needed. There is NEVER enough storage room for supplies and other demand increases during these types of events.