DESIGNING FOR HEALTH

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Since July 2008, the healthcare interior design leaders at Perkins+Will have been authoring Contract’s web-exclusive, monthly article series, “Designing for Health.”

Our focus remains on the powerful influence that design has on healing, and reaching people in more thoughtful ways. In 2014 we explored broader concepts of wellness; from specialty practices, to community health, to material and environmental health.

We share this series of articles with the hope that you will enjoy reading about design issues, trends, challenges, and research in the healthcare industry and beyond. We invite you to read future installments of the series online at www.contractmagazine.com.

Happy reading from the entire Perkins+Will team!
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DESIGNING FOR HEALTH
SMALL SPACE, BIG MESSAGE
Emily Shea Beck, LEED AP and Jordan Thompson, AIA, NCARB, LEED AP

Children’s Medical Center Dallas uses a small renovation to effect cultural change.

**The Problem**
At Children’s Medical Center Dallas, an organization of more than 3,000 people and 200 departments, three groups were to be co-located in a new space: Engineering, Safety, and Planning Design & Construction. The three groups, totaling about 50 people, had never shared the same floor or even the same building. Each brought their own work processes and culture. Due to spatial constraints, the new space would require a shared open-office setting. This would be their first project under a new way of working, as they developed a vision for their new environment.

**The Approach**
The user group wanted the space to embody a new way of working for the three departments. The space should be a projection of their values and the changes already underway – changes in their staff, roles, and focus. The space would literally be a message: This is who we are. The message is to be promoted internally to their own staff and colleagues, and externally to visitors and consultants.

In a healthcare environment, Engineering, Safety, and Planning Design & Construction needed a space that would
unite them as it educated the greater organization on the value that they provide. When implemented, the design will help the three teams to speak with one voice. In this way, the space will be both a tool for change and for in-house marketing.

In developing a strategy for change management, the leadership opened a discussion to the users. Through a democratic process, all stakeholders had a voice. As a result, Children’s was able to incorporate lessons from across disciplines. The users, many of whom are designers, project managers and standards managers themselves, took ownership of ensuring that the space would adapt to their work styles.

The Solution: Principles
A part of the change management process was an exercise to develop a core list of seven principles for the three teams: Stewardship, Sustainability, Patient Focus, Service Excellence, Innovation, Collaboration, and Safety.

Those values informed the design process, such as a desire to establish a collaborative working culture. In writing for Harvard Business Review, Professors Anne-Laure Fayard and John Weeks attribute successful collaboration to the three Ps: Proximity, Privacy, and Permission.1 In this space, these goals were realized through a balance between public and private amenities: smaller conference rooms, flexible furniture, and touchdown stations. For private offices, larger sidelights encourage visibility and accessibility.

“Stewardship is another core value,” observes Judson Orlando, Director of Planning, Design & construction at Children’s. “It’s an important concept in today’s healthcare environment, so challenging ourselves to be creative but decrease our overall costs is a story we wanted to shine through in the solutions.”2 Just as the users are tasked with making informed decisions about how to allocate the organization’s limited resources, the design of their own space would be no different.

The Solution: Practices
To ensure that the design was true to the working styles of the team, they determined the design practices that they wanted to employ in this space as a reflection of their core principles. The list of specific initiatives ranges from vinyl-free materials to a construction waste management plan, but each strategy can be categorized according to these six general practices: Recycling, Energy Savings, Solar Power, Water Conservation, Human Health, and Time and Money.

The space became a lab. Building-standard materials and assumptions were challenged. Re-selection of products and materials were based on four criteria: life cycle cost, sustainability, maintenance, and future integration. The acknowledgement that this space would serve as a test lab for future work in the hospital alleviated some fear of taking risks with the design. It empowered the team to experiment. This too was a manifestation of their core values. Each critical design decision could be filtered through these lenses. In some cases, the boost to the sustainable culture or the probability of future use helped to justify a higher first cost product.

The new space will serve as a living example of space functionality that could be leveraged as a marketing tool for future Children’s projects. Industry partner Herman Miller finds value in fostering change. “Good change management… builds change adaption skills so that the next change is easier,” the company said in a recent research summary.3
Another tool for promoting brand was the use of architectural graphics. The imagery was developed from both the principles and practices. They record the story of the space—how it was designed, the goals pursued, and what they achieved in the end. It celebrates success. But the graphics also serve as a reminder to themselves—what they hold dear, why they do what they do, and how they want to achieve it. The graphics are part of the progression through the space.

There is a hierarchy to the graphics:

1. Large-scale silhouettes provide an overview of design solutions and values
2. Large-scale words list the seven principles
3. Small-scale decals highlight individual design solutions

Each graphic has been thoughtfully placed based on visitor and staff workflows. As a nod to the Stewardship principle, the Children’s Planning Design & Construction team opted to print and install the majority of these graphics in-house. “We wanted the artwork to embody the design intent and vision of our departments and the organization’s mission. We worked to develop inexpensive flexible solutions through use of oversized graphics, vinyl appliqués and signature stamps that each help tell the story,” Orlando noted. “They inspire not only those who live in the space, but others who visit.”

On the whole, the space is a story of change management. It embraced a user-driven process to identify who they are as a new group and where they want to go. This drove the design. In the years ahead, the design will help them stay focused on those goals.

**Sources:**

2 Interview with Judson Orlando, CHFM, Director of Planning, Design & Construction, Children’s Medical Center Dallas. Dallas, Texas. December 19, 2013.
Oral health is an important component of primary health care, but one that many do not receive. 45 million Americans do not have dental insurance,¹ and the Affordable Care Act does not require dental coverage for adults. Even with coverage, finding a dentist has become increasingly difficult. An estimated 30 million people live in a Federally Designated Health Professional Shortage Area and lack access to a dentist.²

Those living in designated shortage areas and underserved communities may soon be able to find affordable care at a Health Center. Since 2010 and the passing of the Affordable care Act, we have seen an increasing number of Community Health Center and Federally Qualified Health Center (FQHC) expansion projects. Most of these include a dental program where preventative services are provided regardless of an individual’s ability to pay. In 2009, 75% of Federally Qualified Health Centers (FQHC’s) provided dental services.³

Federally Qualified Health Centers are health care organizations that serve low-income patients in medically underserved areas, and meet specific criteria qualifying them to receive a number of financial benefits. These benefits include government grants and increased Medicare and Medicaid reimbursements. They provide comprehensive primary medical, oral, and behavioral health services, as well as enabling services such as transportation and translation. They serve individuals of all ages, regardless of a person’s ability to pay. The federal statute governing FQHC’s requires them to provide preventive dental services. Community Health Centers are similar to FQHC’s, but they do not receive federal grant funds under the Health Center program.
Although the Affordable Care Act (ACA) does not require dental coverage for adults, it is one of the primary reasons for the surge of Health Center projects. The ACA has allocated increased funding to Health Centers in an effort to provide high-quality care to the large number of newly insured, especially those in underserved communities. The increased funding is also intended to help Health Centers expand operations by increasing the scope of medical, dental and behavioral health services provided. As a result of this increased funding, many are currently expanding their facilities or building new ones.

Community of Hope is one of the many Federally Qualified Health Centers that are expanding. Their recently opened headquarters in Washington DC includes 11 dental operatories. Kelly Sweeny McShane, Executive Director at Community of Hope, says “There is a real shortage of dental care in our community, especially for low-income adults. While it is a requirement of FQHCs to connect patients to dental care, we found that it was hard to find dentists who would accept Medicaid or the uninsured. Community of Hope, therefore, began providing direct dental care, with our own dentists. We have recently expanded the amount of dental care we provided due to unmet need, and see that it will become more important in our service offering. We also believe in creating integrated care, which includes oral health.”

With this surge of expansion comes the opportunity for designers to help shape a new experience of primary health care. Perkins+Will has been working closely with a number of Health Centers and has developed a specialized understanding of their similarities and, more importantly, what makes each one unique. It is important to understand that a Health Center’s personality is greatly influenced by the community it serves. As geography and demographic makeup vary, so do needs and preferences. There are population-specific health concerns, as well as cultural, language, financial, and safety considerations. There are social needs like homelessness and education. Even aesthetic preferences and finish appropriateness varies from one community to the next. As a result, each Health Center requires it’s own brand identity. One Health Center should not look and feel just like the next.

It is estimated that 9–15% of Americans, or 30 to 40 million people, suffer from dental anxiety. This often leads to patients avoiding trips to the dentist, which can ultimately lead to a series of health complications. Therefore, creating a positive patient experience is as important for dental clinics as it is for medical clinics. A
long wait time is a sure way to increase patient stress, so thoughtful space and operational planning can be implemented to gain efficiencies that improve patient flow and reduce wait times. One example of this is installing X-ray machines in every operatory, so patients do not have to be moved and then wait for use of the machine. In addition to improved flow, patient anxiety can be eased by creating bright spaces with access to natural light, and by introducing architectural elements and artwork as positive distractions.

There are fewer healthcare code restrictions for dental practices than traditional medical spaces, which creates expanded design opportunities. Freer regulations allow for more open planning concepts that utilize glass, partial height partitions and translucent screens to bring daylight deeper into the floor plate. With fewer infection-control restrictions, many clinics are considering shared common support elements between operatories, like sinks and X-ray machines. This not only cuts down on initial capital cost, important for any FQHC, but frees up space in the plan to incorporate artwork and other elements of positive distraction.

The trends we are seeing in oral healthcare environments, from expansions in underserved areas to the crafting of branded experiences, are just a small part of the changing healthcare design landscape. As implementation of the Affordable Care Act continues, designers will see the growth of certain project types and the emergence of others. This is an exciting opportunity for designers to help shape the future of healthcare spaces and redefine the patient experience.

SOURCES:

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DESIGNING FOR HEALTH
CONTEMPORARY SIMULATION DESIGN OBJECTIVES
Nadia Kulczycky, LEED Green Associate

The contemporary context for the expansion of simulation design in medical education is affected by two factors: government policy and demographics. The Patient Protection and Affordable Care Act has given an estimated 32 million new people access to the healthcare system, creating a greater demand for well-trained healthcare professionals. The generation that will fill this gap consists predominantly of millennials, a large emerging workforce shaped by social networking, video games, multi-tasking, and the need to always be connected. They have grown up with rapidly changing technology as a normal part of life and consequently a new breed of student has been created. This distinctly new type of learner thrives on rapid access to information and a dynamic interactive learning environment. Thus the millennials are uniquely poised to benefit greatly from advanced technology in the medical learning environment. However, these advancements create new challenges for the instructors who are more familiar with traditional methods of teaching.

Because the primary role of an educator is to provide the best available instruction to the learner, it is crucial for traditional methods of education to morph with the rapid technological advancements. As our technological capability continues to expand according to Moore’s Law, doubling the processing speed of computing hardware every two years; the way we educate and the way we design the space within which we educate must also continue to evolve at a similar pace. Continued rapid expansion of technology is a reality that educators must incorporate into how they plan their curriculum in order to assure this new technology is not a distractor but an enhancer of learning.

Simulation is currently recognized as one of the best methods to expedite and facilitate the transition from...
student to healthcare professional by providing experiential learning which never puts the patient at risk. It allows for deliberate practice in a controlled environment where students learn through experience, reflective practice, and immediate feedback. This process accelerates the student’s development of critical medical skills and improves their performance on both an individual level and as members of interdisciplinary teams. As a result the student’s proficiency is at a high level prior to engaging in professional healthcare practice and thereby meets the medical professions’ overarching objective of increasing the quality of patient care and safety.

The use of educational simulation is not a new trend; it has been used in the military, aviation, chemical and nuclear industries for decades. It was first introduced into the medical field about 15 years ago and since then has been rapidly evolving to a point where highly realistic medical simulation is now possible and practical. As such the application of simulation in medical education is an important tool.

Aligning the design of the simulation facility with the school’s curriculum is a key design objective. Thus, no two facilities are alike. However, below are common programmatic areas typically included in the design.

- **Patient Simulation Rooms.** These rooms simulate the existing rooms in hospitals.
- **Observation Rooms.** Where educators view student activity into the simulation rooms through one way glass and can interact when needed with the student through audiovisual equipment.
- **Debriefing Rooms.** Where students receive feedback on their performance and reflect on their behavior after the simulation experience.
- **Skills Lab.** Where students can practice clinical knowledge on mannequins.
- **Standardized Patient Rooms.** Clinical exam rooms where actors are used to simulate patients.

Note that the simulation design may provide additional opportunities for the instructors that were previously not possible, therefore the instructors may want to modify their curriculum to enhance their teaching options. It is also important for the design team to visit existing facilities to understand the capabilities of simulation in an educational setting.

The overall design of a simulation facility is driven by technology. Audiovisual equipment connects the rooms through video cameras, microphones, and speakers. The ability to view real-time footage of the scenario on site or
remotely greatly facilitates the learning process. Current evolving technologies within simulation centers focus on the use of sophisticated computerized mannequins which are anatomically precise and reproduce accurate physiologic responses. Therefore the design must consider that this technology will continue to evolve (Moore’s Law) and as such the facility should be designed to accommodate routine upgrades.

A very important consideration that must be emphasized to the training facility staff is that the lack of trained personnel to support simulation can pose a significant liability to the success and ultimate functionality of the simulation center. At a recent conference held for the Society of Simulation in Healthcare, Professor David Gaba, Associate Dean for Immersive and Simulation-based Learning at the Stanford School of Medicine, stated, “Flexibility is key when designing simulation facilities. There is zero installed casework at Stanford University. The AV system at Stanford is extremely powerful and flexible in design, however it is so complicated only a few know how to use it correctly.”

Flexibility in the audiovisual infrastructure, services, equipment, and partitions can create an environment where multiple simulation scenarios can be performed, and future enhancements can be easily implemented; but without well trained staff available the entire project could be perceived as a failure.

There are many emerging technologies in medical simulation, which include the use of serious games and virtual learning environments. Serious games is a method of game based learning where virtual environments have been specifically engineered to accurately replicate an existing medical space such as an operating room or an exam room. Within these environments exists a virtual patient, whom students are challenged to assess, diagnose, and treat. The concepts of this simulation must be well understood by the training staff to avoid, as noted previously, startup problems that could lead to poor results and client rejection.

The accessibility to an infinite expanse of knowledge through the mobile internet changes traditional models of education. Now students and teachers can connect from any geographic location through ‘virtual discussion space’. This has resolved distance issues amongst interdisciplinary teams, and provided students with contact to their instructors whom are not on site. As students progress and equal or exceed the capability of their local instructors, they can now expand their training to specialized expert instruction from anywhere in the world. This not only changes the traditional methods of interaction amongst students, but also transforms the way architects design space; we are no longer restricted to the walls which we build.

As the millennial generation continues to enter the medical work force, and technological advancements in simulation and virtual environments rapidly evolve, the need for flexible educational modalities and facilities has never been greater. Simulation and its accompanying technologies truly transform the way medical students learn, and architects design; there is now a limitless expanse of space which buildings can inhabit, and students can learn. If the implementation is well managed and applied intelligently the possibilities are endless.

SOURCES:


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The trend is for Healthcare systems to bring healthcare portals closer to the patient’s workplace, in more appealing and accessible facilities. These signature spaces help spread the institution’s identity throughout the community, blend a multitude of specialties for enhanced and collaborative care, and importantly, heightened convenience for the patient. Design plays an important role in creating the overall impression of these space, and serves as a vehicle to enhance one’s impression of the particular client. Aesthetics and spatial solutions are progressing away from those that have been easily identifiable as “healthcare,” and increasingly recalling other sectors. This is in step with the overarching trend of the new hybrid environments: residential-workplace, wellness-workplace, and now hospitality-healthcare.

These centers often are in commercial buildings to enhance patient access through geographic proximity, with welcoming facilities and programmatic diversity that supports clinical workflow, collaboration and communication, in a one-stop patient destination. Limitations in floor-to-floor heights, and accommodation of engineering requirements and diagnostic and treatment equipment can be a challenge in commercial office buildings, but can be overcome. When healthcare institutions and Design team up in support of strategic business goals, the end product can realize greater aspirations, and create destinations of choice. Good design is good business.

Multi-specialty practices are also the trend. Beyond convenience for the patient, a benefit to clinicians is to
be in proximity to their complementary peers. This is the case for many types of workplaces. Extensive research, such as a recent study from the University of Michigan Institute for Social Research, demonstrates that there are obvious advantages to bringing distinct but mutually relevant departments into physical proximity. Benefits include increased formation of new collaborations, which increase and improve the quality of information sharing, in turn improving the odds that everyone is up to date on the latest developments in each other’s departments. In addition, collocation of multiple specialties significantly increases opportunities for all members of a care team to share information about a patient, with the objective of more seamless care.

At New York University Langone Medical Center (NYU LMC) in New York City, the new Center for Musculoskeletal Care is an intentionally integrated facility, including both clinical care and biomedical research resources for bone and joint patients. The comprehensive program includes treatment spaces for sports medicine, spine, arthritis, autoimmune disease, sports injuries, and total joint replacement along with radiology, infusion therapy, rehabilitation and pain management. In addition, the Seligman Center for Advanced Therapeutics is incorporated within the Center, along with an infusion suite, which collectively support ongoing clinical trials of new therapies. Doctors are able to have daily engagement with their patients’ rehabilitation via proximity. An interconnecting stair with city views and a design that invites use, connects to the rehabilitation practice. It’s everything a musculoskeletal patient would want, including a rehab gym with river views, which appears more executive health club than clinic.

In the compact but highly diversified Preston Robert Tisch Center for Men’s Health, collocation to uniquely serve men and their concerns is the target. With an ambiance that recalls hospitality, an airline’s business class lounge or sophisticated office, this recent addition to NYU Langone Medical Center caters to the contemporary urban male, offering a vast range of medical services that focus specifically on men’s health: cardiology, dermatology, endocrinology, gastroenterology, neurology, orthopedics, urology, and more. Specialists from these various areas are able to serve patients and also communicate daily with each other. As a patient, one’s entire array of doctors are not only on the same page, they are in the same inviting place.

A final and increasingly emphasized aspect of patient outreach is branding. This includes everything from attention-grabbing messaging by the NYU LMC client, like full-page advertisements stating “Men Have Needs, Too,” to ensure that a health system’s portfolio facilities
have a cohesive identity despite each having a distinct look and feel. For example, in the case of the Center for Musculoskeletal Care, the exposed structure and main staircase have a distinctive and subtly skeletal form, while the Center for Men’s Health features a range of handsome and highly textural finishes that recall bespoke menswear. The final effect is that the patient has a clear sense of place at each facility, but also understands the high quality of the experience that he or she will have at any center within the NYU Langone system. The patient-centered, concierge-like sensibility is always tangible.

Considering how “insulated [the healthcare industry has historically been] from consumerism” when compared to other highly competitive industries, such as hospitality, effective branding may become the key to success for today’s healthcare systems. And while hospitals are currently “hiring consultants from Disney and Ritz-Carlton to teach them how to improve patient experience,” perhaps other industries will soon be looking to healthcare for lessons on gaining market share in style.

SOURCES:


3 NYU Langone Medical Center website for Preston Robert Tisch Center for Men’s Health. http://www.med.nyu.edu/menshealth#panel-2


5 Riggle, Jenn, “Patient-centered care must-haves: Convenience, flexibility.” Hospital Impact. 9 January 2013. http://www.hospitalimpact.org/index.php/2013/01/09/patient_centered_care_must_haves_conven...
DESIGNING FOR HEALTH
THE BRAND EXPERIENCE

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As consumers, we all know the power of branding and the resulting emotional connection we feel to the brands we support. We buy our coffee at the same coffee shop because we feel good about how the staff treats us. We frequent the same hotel chain because we like that it feels like home. We buy the same brand of car because it makes us feel important.

The feelings we experience when we interact with brands aren’t by chance; rather, they are the result of very conscious and concerted efforts by the brands themselves to elicit those feelings and, as a result, create loyal customers of us.

While branding is an age-old means of driving awareness, sales and profitability in industries from retail to hospitality to automobiles and more, it has not been a driving force in healthcare. Historically, healthcare providers have assumed that patients would find them when they need them; and, since nearly everyone needs medical treatment at some point or another, branding was considered somewhat superfluous.

Not anymore. With consumers coming to expect convenience and accessibility in nearly all other service-related industries, retail health clinics hit the marketplace in record numbers offering just that.

With little to differentiate one clinic from another—many are located within big box retailers; most offer competent but limited health services and screenings; a majority are non-descript, bare bones facilities with little in the way of amenities; and nearly all compete on price as much as they do on convenience and accessibility—health providers turned to branding to make a name for themselves. They embraced colorful logos, catchy slogans, and interruptive signage as they vied for patients.

**Breaking away from the pack**

Recently, a leading national health services business with no direct patient care decided to enter the competitive retail
health space with doctor-staffed urgent care facilities in several states. While their competitors were busy targeting patients wanting low-cost, walk-in healthcare, this company decided to target patients seeking not only convenient, accessible and affordable healthcare, but a premium healthcare experience. The company’s belief was that retail healthcare providers all offered comparable competent healthcare services, convenience and so on, so the way to stand out was through the patient experience, building a consumer-facing brand from the ground up that was highly experiential in nature.

The company took several critical branding steps as it broke away from the pack. First, it recognized that its patients were not just patients but discerning consumers—consumers with access to a plethora of healthcare options ranging from primary care facilities to urgent care centers to retail health clinics. Second, it understood that to effectively appeal to its target market, it needed to embrace branding not just as a logo, a slogan and signage but as a means of designing the collective patient experience. Third, it hired a design partner with a reputation for creating branded expressions, experiences and environments.

The design team recognized a need to research non-healthcare businesses and brands that also provide a premium experience and identify what, specifically, helped create that experience. They turned to boutique hotels, spas, restaurants, and concierge services, and noted everything from the color palettes and furnishings to the check-in process and use of technology. The design team identified every touch point that would or could impact brand perception and the patient experience, and they took the best of what they saw in other service industries and translated it all to the delivery of healthcare.

**A healthcare experience by design**

With a simple and soft color palette, marble countertops, wood wall coverings, porcelain floor tiles, and even throw pillows and beautiful floral arrangements, the resulting clinic design exudes the level of sophistication, refinement and timelessness common in a luxury hotel or high-end retail setting but atypical for a healthcare setting. Because well-appointed materials are used sparingly and colors are used conservatively, the clinic design lends an inviting, approachable and comforting impression while keeping built out costs at a minimum.

While the delivery of healthcare must be personalized to the patient, this clinic takes personalization to a new level. One suggested design component was the use of patient recognition software that would allow a concierge to greet patients by name upon arrival and present them with their beverage of choice based on their preference profile. While that idea has not yet been implemented, the lobby design does allow patients to check-in privately via tablet or more
traditionally via a concierge at a reception desk. Patients can enjoy a cappuccino or a bottle of mineral water as they work at a technology bar or relax in a hospitality-like arrangement of modular sofas that accommodate individuals or entire families.

The clinic also offers a number of unexpected customer service extras such as tablets for patients and family members to use throughout the visit to replace outdated magazines and loud television sets, and a program that rewards loyal patients with spa services and treatments, such as massages. In addition, the clinic provides both triage and diagnostic services to ensure patients are catered to as much as possible during a time of discomfort and need.

In the end, this new retail health provider has embraced the mantra that “brand is king,” and, in doing so, has created a highly differentiated retail healthcare experience that is sure to win loyal patients who will equate the brand with a feeling of being pampered and well cared for. It’s the kind of feeling that could very well create long-term change in how other healthcare providers go to market in the future.

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We concluded the first day of training with a combat exercise. Clint, playing the part of an enemy combatant, disappeared deep inside the derelict motel. I was completely helpless to slow my racing pulse or quiet my panting breaths. At that moment, I was as close as a civilian can come to experiencing the stresses of urban warfare. Clint and I were the only two people in the building, wielding nothing more than paintball guns. This was where my research on designing for veterans with post-traumatic stress disorder (PTSD) became real.

Veterans are an important and interesting demographic: they are ethnoculturally, socioeconomically, and geographically diverse, but at the same time are unified by the military’s standardized training, which affects perception as well as emotional reactions. To get a better understanding of how a veteran perceives and reacts to their surroundings, I partnered with Corporal Clinton McMahan, U.S. Marine Corp veteran, from whom I received hands-on training of military observational techniques. We focused on methods used to identify threats in indoor and urban conditions, as these are the most common environments veterans will encounter upon their return to civilian life.

When I was working with Cpl. McMahan, we visited Safety Wolf Paintball, a motel that has been converted to a recreational combat sports facility. To add “character,” the owner painted the walls with what look like bloody hand prints—an unsettling and highly complex, non-repetitive, pattern.
To a combat veteran, a walk down the corridor at Safety Wolf might be perceived as dangerous because the complex pattern could easily camouflage threats, and therefore must be examined carefully. The intentionally high level of visual complexity achieved here produces a high “cognitive load,” requiring more energy and focus to distinguish what is important from what is not. While the pattern on the walls of Safety Wolf isn’t something we’d likely see elsewhere, a multitude of switches, sensors, rails, moldings, textures, and colors could be equally consuming.

Considering a holistic picture of health, PTSD can be a complex problem, as it can involve a range of anxiety-related symptoms stemming from a traumatic event. Memories of traumatic events can be stored differently than typical memories. Specifically, trauma memories are often fragmented, non-verbal, and disjointed in time, but can be easily triggered by similar stimuli. For example, a veteran of the Vietnam War may hear the sound of a helicopter harmlessly surveying traffic conditions and suddenly feel or act as if their traumatic event is happening all over again.

All of the human body’s biopsychosocial systems operate within the same organism; what one system uses, another cannot. Thus, the more energy we spend to cognitively process stimuli, the less energy we have for other necessary tasks that are a part of optimal functioning of our brain and body. With this in mind, designers can begin to facilitate psychological healing from PTSD by reducing the cognitive load of the environment.

Although PTSD is a difficult condition, it is not without hope. Most people who experience trauma do not develop PTSD; when it does develop, it can typically be overcome with psychotherapy for trauma-related symptoms. Dr. Edward Vega, a psychologist for the Department of Veterans Affairs, points out that cognitive-behavioral treatments for PTSD, such as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), are very effective at helping individuals overcome the impact of trauma in their lives. “The common elements of the therapies that work best appear to be helping people to confront rather than avoid things that are predictably safe but make them anxious,” says Vega. “They also help people to examine and challenge their own thinking about the traumas they have experienced, and how these events may have changed how they look at themselves, other people, and the world around them.” Confronting the triggers of one’s anxiety can be very taxing, but ongoing practice reduces the anxiety reaction over time.

The built environment alone cannot solve PTSD, but it can help. To illustrate environment’s ability to impact
psychological wellness, let’s take another look at the corridor at Safety Wolf Paintball. With their intervention, the owner has effectively increased the cognitive load of that environment, which can be seen as appropriate for this building used for combat sports. At the opposite end of the spectrum, when considering a space for psychotherapy, we should aim to reduce the cognitive load.

It is important to differentiate between how the built environment and psychotherapy can cooperatively contribute to recovery. Reducing the cognitive load of an environment isn’t intended to avoid confronting one’s trigger, but to prevent the patient from becoming overwhelmed by an excessive quantity of stimuli or by being unnecessarily exposed, as exposure would ideally occur initially in a controlled, deliberate, and constructive manner. Dr. Vega sees many similarities between exercising for physical and mental health. “When you intend to stress muscles beyond their usual capacity, you should warm up first. Over time, this can make your body stronger and more capable for a wide variety of activities.” Considering the use of tools, Dr. Vega says “well designed fitness equipment can help focus exertion to the targeted muscles, building strength efficiently. Similarly, a well-designed psychotherapy environment can help focus attention and energy in the right areas, with less wasted effort.” A reduction in the cognitive load of a space where therapy occurs, and the entire procession to this space, allows more of the patient’s energy and focus to be dedicated to the task at hand.

While this example focuses exclusively on visual cues, we know that stimuli detected by any of our senses can trigger excessive anxiety. We also know that, regardless of mental state, the cognitive load of our environment affects the amount of energy required to process it. A reduction of the cognitive load of one’s surroundings has the potential to benefit anyone undergoing any taxing process, be it healing from a physical or psychological wound, or undergoing a personal or professional cognitive challenge.

As designers, it is within our power to create spaces that promote wellness on many levels. By examining the case of veterans with PTSD, we can begin to learn lessons applicable to any healing space and better understand how design can facilitate truly holistic wellness.

For more information on this topic, please read the full Post-traumatic Understanding report (PDF) on designing for veterans with PTSD.

SOURCES:


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DESIGNING FOR HEALTH
A TIME TO PLAY; A TIME TO HEAL
John Michael Day, AIA, LEED AP BD+C, Jonathan Hoffschneider, AIA, LEED AP BD+C and Tatiana Escobar, AIA, LEED AP BD+C

Children’s National Medical Center is considered one of the top facilities of its kind in the nation and is the flagship facility of the Children’s National Health System. As a global leader in the diagnosis and treatment of a broad spectrum of childhood diseases, Children’s National has a child-centered vision, which looks at the hospital experience through a child’s eyes. In this way, the facility and the staff work together as a team to create “a bright and happy place that feels like home” where patients and their families can find everything needed to bring them back to health.

Children’s National has a network of regional, integrated outpatient care facilities that reaches deep into the community. When required, the most challenging and complex patients receive focused care at the hospital, which also serves high-risk patients from around the world. Due to the threat of complications, these children are often treated for extended periods of time under extremely restricted conditions. As a result, the hospital faces a common challenge in health care: how to provide safe and comfortable places of respite from the antiseptic, manufactured surroundings required by the most advanced diagnostic and treatment methods.

To these children—often the sickest of the sick—much is expected of their growing bodies and their developing minds. Unfortunately, due to medical restrictions and the vulnerability of their weakened defense systems, children have a very limited or no access to nature during their stay. Within this highly-controlled setting, the physicians, nurses and staff of Children’s National have developed a vision for a dedicated outdoor rooftop healing garden. The garden will help to restore a child’s innate connection to nature while they do battle with illness, the side effects of medicine and their own physiology. In planning the healing garden, designers, clinicians and patients’ families are rethinking their assumptions and preconceptions about their patients’ contact with nature during treatment. In the process, planning for it could assist the patient in their recovery during the long road to recovery.
“My providers, my family, and I are a team, and everyone’s job is important. The way my hospital works is built around me. My providers don’t all look alike. My hospital is my family’s connection to everything I need for my health, whether they provide it or blaze a trail to it.”

—Children’s National Medical Center Patient’s Creed

The last line of the Patient’s Creed serves as a consistent reminder of the motivation that led to the vision of the healing garden. The last wish of a critically ill patient inspired Children’s National and to create an outside space that would be open year-round to the patient population and their families regardless of their illness. The Patient’s Creed also serves the inspiration for the visioning process to align the child-centered vision with the parents’ and clinicians’ goals.

The proposed healing garden area is currently a gravel-covered roof on the Third Floor of the medical center with sweeping views of the National Mall to the south. To help the children formulate their vision for the healing garden, a design charrette was held in a room overlooking the proposed low roof location. The Design Team constructed scaled models of the roof area. They also provided art supplies such as paper, glue, tree cut-outs and stickers in a wide range of shape and colors. No sooner had the patients arrived at the charrette, their creative ideas started to flow. Imagery of flowers, animals and even super heroes began to fill the models and drawings. The patients worked in the manner they each felt comfortable: some used the models to create dioramas, while others felt more comfortable drawing their idea or expressing their thoughts through words and poetry. While calming music played in the background, a consistent set of ideas began to take shape around play, discovery, and nature. Many of the ideas were based on “everyday” experiences that one would have at home or at school such as playing “2 Square,” having a lemonade stand, visiting the zoo, watching a movie, listening to music, reading a book under a tree, relaxing at the beach, of just getting off your feet somewhere in the shade to cool down. It became evident that for the patients, the healing garden is to be a place of personal retreat and a positive social gathering place for friends and family.

Concurrent visioning sessions with the parents and the clinicians were designed to be more structured and focused on the principles of biophilia. With increasing evidence that human health improves through contact with nature, the design team created an image-based value system modeled around seven main characteristics: 1) environmental features, 2) natural patterns and processes, 3) place-based relationships, 4) family, 5) natural shapes, 6) light and space and 7) human relationships to nature. In an effort to filter out preconceived design ideas, selected imagery paired with these categories allowed parents and clinicians to create a hierarchy of design ideas and strategies that could be used to create the garden program and support future design decisions.

One example is a collection of images grouped under the “natural pattern and process” characteristic. They included children’s hands covered with colorful paint, a girl smelling a flower, an open grassy field edged with a curved forest, and a path bounded by tall bamboo shoots. Descriptive words identified concepts such as sensation, boundaries, transitions and hierarchy of scale supported the imagery.
Each of the participants was asked to select one or two images that best supported their understanding of the biophilic characteristic. In this example, the most popular image was the children’s hands covered with colorful paint which, for many, represented the opportunity to create an art wall or creative zone within the healing garden to create sensory variety. This feature could in turn, create sensory variability and transitional spaces within the healing garden. At the end of this visioning session, it was a powerful lesson to recognize how the goals established with the parents and clinicians aligned closely with children’s goals as well as those of the Patient’s Creed.

As the design and construction of the healing garden progresses, the process will continue to be supported and informed by the vision and goals of those who work here, the families of those who are treated here and most importantly, by those who travel to Children’s National from near and far and who, for a short time, live here as they rest and heal.

**SOURCE:**

DESIGNING FOR HEALTH

POPULATION HEALTH THROUGH THE CLIENT’S EYES

Jason Harper, AIA, LEED AP

During this period of rapid and accelerating change in our health care system, as it shifts from a volume-based to a value-based model, are we as designers for healthcare keeping pace? How is the role of the healthcare institution changing, and how should this change how we design for healthcare? What can we do as designers to help guide our healthcare clients through this disruptive paradigm shift?

It is clear that health systems are now more outwardly focused than ever before. Many are pushing as much of their care as possible into outpatient settings that are closer to the communities they serve. Many are developing more comprehensive health systems through acquisition and collaboration. These are all ways in which they are responding to the new incentives for prevention and wellness, and the need to gain efficiency and reduce unnecessary healthcare costs.

The increasing focus on population health means that we, as designers, need to look beyond the four walls of the facilities we design. How should hospitals and healthcare facilities relate to their communities? How can their design have a positive impact on the community and on population health? Sustainable design has been one way that we have been able to reduce the external impact of what we design on our environment. By focusing on the scientific evidence of material health\(^1\), energy efficiency, mechanical system selection, and building envelope design in a systematic way, we have been able to bend the curve of our environmental impact downward. We can extend this way of thinking to also help bend the curve of chronic disease rates and rising healthcare costs downward by reducing the negative impact of what we build on public health using the same evidence-based approach.

So let’s, for a moment, imagine that we are the healthcare client, struggling to decide how to best utilize our resources to increase wellness and reduce the cost of healthcare within the community we serve. When considering the next facility to invest in, what strategies would be most effective in health outcomes? An interesting resource to help answer this question has been provided by County Health Rankings & Roadmaps\(^2\), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. Their roadmap—“What Works for Health”\(^3\)—identifies the strategies that work, and rates their effectiveness on health outcomes\(^4\), based on scientific evidence. In their methodology, clinical care accounts for 20% of what drives health outcomes.

Wait, what? All of that clinical care in all those facilities that we have built over the years impacts a mere 20% of health outcomes? What accounts for the other 80%? Well, according to their outline, Social and Economic Factors—such as education, employment, income, family & social support, and community safety—have a 40% impact on health outcomes (twice the impact of clinical care). Health Behaviors—such as tobacco use, alcohol and drug use, diet and exercise, etc.—account for 30% of health outcomes, and the Physical Environment—including air and water quality, housing, and transit—accounts for the remaining 10%. Based on this
understanding, how should we spend that facility dollar? What should our programmatic and design priorities be? What design features should our facilities include to be most effective in health outcomes, beyond the clinical care that will be provided within their walls?

By seeing in this way, through our client’s eyes, and through the lens of what really effects health outcomes, we can gain a whole new way of understanding of how design can bend the health and wellness curve. We are already focused on sustainability at the scale of material choices and building system selection. Next, we can begin to look more outwardly at the scale of the block, campus, community, district, and region—as our clients are beginning to—to better understand the impact of our design decisions on population health.

Using the weighted strategies outlined in “What Works for Health” as a starting point, we can identify the most effective strategies that we can employ as designers. Designing great and efficient settings for clinical care (20%)²⁴, while using the best evidence-based strategies to impact health and healing is what we are good at, and where we have been focused for some time. Check! But how can we go beyond that 20%? What about Social and Economic Factors (40%)? What if we designed healthcare facilities to be more welcoming and integrated into the community? Could our designs encourage staff to shop locally or go out to the local café for lunch instead of the hospital cafeteria? What are the design features that can increase safety in the community surrounding the facilities we design? Are we integrating safe and inviting pedestrian and bicycle paths into our projects? Do we concern ourselves with strategies to calm traffic and to create safe pedestrian refuges?

And what about Health Behaviors (30%)⁸ and the Physical Environment (10%)⁹? The strategies outlined in the Active Design Guidelines outline opportunities for physical activity in our projects. Incorporating healthy food venues, community gardens and farmer’s markets into our projects can encourage healthier diets. As Richard J. Jackson, Professor and Chair of the Department of Environmental Health Sciences at UCLA, points out “More than ever before, Americans today are faced with poor nutrition and lack of physical activity, both of which are leading to serious health consequences”¹¹. Integrating green spaces in our projects can also encourage engagement with nature. Including corner stores and designing great streetscapes and pedestrian-focused public realms can add vitality and safety to the community. Rather than assuming that cars are the preferred means of access, we can allow for more active means of commuting.

The emerging focus on population health is challenging our clients to find new strategies that go beyond business-as-usual. This rapid change offers an extraordinary opportunity to utilize our unique skill set as designers to impact public health and wellness in innovative ways. As our clients widen their horizons to consider how they can impact the health and wellness of the community as a whole, so should we. “Build it and they will come” no longer makes sense. What we need to do is to build so that fewer will have to come.
County Health Rankings & Roadmaps —“What Works for Health”.  

The “What Works for Health” roadmap identifies the strategies that would be most effective in health outcomes and rates their effectiveness based on scientific evidence.

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Health Behaviors —
Diet and Exercise: http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12058

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Air & Water Quality: http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12061  
Housing & Transit: http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12060


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DESIGNING FOR HEALTH
BEYOND COMPLIANCE AT SPAULDING
REHABILITATION HOSPITAL

Juliette Bowker, IIDA, LEED AP and Jeffrey Keilman, AIA, LEED AP

It is estimated that 15 percent of the world population lives with some sort of disability.\(^1\) These disabilities are diverse and vary from one individual to another. Because one of the roles of a rehabilitation hospital is to satisfy the needs of patients at various stages of recovery, the assessment of these needs is a critical part of the design process. For Spaulding Rehabilitation Hospital \(\text{(Contract, October 2013)}\), in Boston, whose mission is to “improve the quality of life for persons recovering from or learning to live fully with illness, injury, and disability,”\(^2\) an inclusive design process that helped to identify and satisfy these needs was critical.

Design can stretch boundaries and create barriers. Minimum standards, as required by law, are an important first step in addressing the needs of the disabled. However, these standards focus mainly on wheelchair and visually impaired accessibility, which do not always work well for people with other disabilities. Can a hospital be designed to be spatially inclusive, not just accessible? Can the design process include a group of individuals to provide broader perspectives and identify a wider range of needs? Can the building function as a therapeutic tool that eliminates boundaries and provides the flexibility for a variety of accommodation? We believe that it can and, in partnership of our client, Partners Healthcare and Spaulding Rehabilitation Hospital, consultants, advocacy and user groups, we addressed these questions in the design of the new Spaulding Rehabilitation Hospital.

**ADA is the threshold, not the end**

Universal Design has been defined as “the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.”\(^3\) Accessibility laws and regulations are minimum standards and do not necessarily satisfy all users’ requirements. Universal design is adaptable to suit the needs of many and it advocates flexibility so that users have choice.

The seven principles of universal design include: 1) equitable use, 2) flexibility of use, 3) simplicity of use,
4) perceptible information, 5) tolerance of error, 6) low physical effort and 7) space appropriate for approach and use. Each of these principles was part of the design evaluation process as we developed our design solutions for the hospital.

**Design process**

“I am proud of the design process,” Oswald Mondejar, Senior Vice President of Mission and Advocacy, Partners Continuing Care, said. It was much more engaged than what we usually do, and it challenged us to be the best that we can be.”

A critical part of our design process was to understand the challenges and barriers that individuals with disabilities face. First, the design team spent a day navigating the existing facility and city in wheelchairs and walkers. Then we built and tested full-size mockups of patient rooms and toilets. Once the mockups were complete, we were able to review them with multiple users to learn what worked and where the shortcomings were.

The most beneficial part to us was the day we spent in a wheelchair. This enlightened us to the challenges faced by those with disabilities every day. We found that even when design meets ADA standards there are still barriers. Because of this experience, each team member was able to be critical of prescribed standards and question design decisions. Everything from the big moves to the small-scale gestures was considered: what slope would best help navigate a wheelchair on the site to the main entrance? How should a sink be designed to enable the greatest use by the most people?

As mentioned earlier, the design was evaluated based on universal design principles. Mockups were built, reviewed, and modified to suit the comments of our client, consultants, and user groups. Below are three examples of design features incorporating these ideas.

**Design solutions**

Site Accessibility: Spaulding Rehabilitation Hospital is located at the end of the Charlestown navy yard on the edge of Boston Harbor. The site includes part of the public Harborwalk system of paths along the water. There are no boundaries between the two, allowing patients and the public access to all of the amenities. The entire site was designed to be accessible to users with mobility limitations, including sitting areas, planting areas, and the waterfront. The site features a variety of fixed and moveable seating, including lean rails, sitting walls, and benches with backs and arms. Site furnishings include an adjustable height basketball goal, inclusive fixed seating, therapy equipment at a variety of mounting heights, and a guardrail along the
harbor edge that does not impede the view of the water for persons seated in wheelchairs.

Sink Design: Accessibility standards require knee space to allow for wheelchairs to pull up and access a sink. While these standards work well for some wheelchairs, the prescribed depth is not always sufficient for larger chairs. Also, a bowl sink can be difficult for people with dexterity issues as they may find the bowl an uncomfortable surface to rest their arms. Custom vanities and sinks were designed for the public, and patient toilet rooms feature a monolithic design and gentle slope with increased knee space. The slope allows a person to rest their arms comfortably to access the faucet, and the increased knee space allows chairs to pull up comfortably under the vanity. The vanity is made of thermoformed, solid-surface material, which is soft to the touch.

Staff Desks and Seating Areas: Staff desks were designed to accommodate a variety of approach options. This includes side and front approach, as well as places to lean and perch. By providing multiple access options, the desks serve a wider range of users. Seating areas are often designed with wheelchair spaces segregated at the end of a row. In real life, wheelchair users may end up sitting in circulation paths so that they can be close to family members. As part of the design, waiting area seating includes multiple configurations with adequate space for wheelchairs and other mobility aids allowing patients and family members to sit comfortably together.

Rates of disability are increasing due to population ageing and increases in chronic health conditions, among other causes. Accessibility codes mandate the basic needs of accessibility but do not always satisfy the subtleties required by end users. Spaces should be designed to be accessible to a wider range of needs. First-hand experience and user input is invaluable for the design team to evaluate the requirements and design effective solutions.

SOURCES:

1 World Health Organization; Disability and Health, Fact Sheet No. 352, September 2013
2 Spaulding Rehabilitation Hospital, Mission Statement, http://www.spauldingrehab.org/
5 World Health Organization; Disability and Health, Fact Sheet No. 352, September 2013

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DESIGNING FOR HEALTH

HEALTHY ENVIRONMENTS—STRATEGIES FOR AVOIDING FLAME RETARDANTS IN THE BUILT ENVIRONMENT

Suzanne Drake, LEED AP ID+C

In the recently published paper, *Healthy Environments: Sources of Flame Retardants in Buildings and Available Alternatives*, Perkins+Will’s Science Fellow, Michel Dedeo, PhD, parses the issues surrounding flame retardants in the built environment. It has long been known that some flame retardants are persistent in the environment, bioaccumulative in people and animals, and/or potentially toxic to many living things. Contrary to popular belief, the paper suggests that flame retardant use in building products can be largely avoidable without compromising fire safety or code compliance.

There are many potential health concerns surrounding some flame retardants(1), and many design and construction professionals have assumed that they were a necessary evil. As the health issues have become more and more prominent, it has also been revealed that some of these chemicals’ efficacy as a safety feature may actually be very limited(2).

Flame retardant use in building products is largely avoidable, which is not always clear to those in the design community. For decades, flame retardants have been added to materials to meet specific flammability code requirements in developed countries. As a result, they are ubiquitous in globally distributed products, and their waste and residue is evident in air, water currents, and in the food chain(3).

The central question is this: In the widespread use of flame retardants, has the industry simply traded one hazard for another?
There is no regulatory mandate to utilize chemical flame retardants, instead there is a performance criteria for flame resistance that must be met. How a material meets the performance criteria is not predetermined by regulatory agency. The agency’s only concern is that the performance criterion is achieved. Specifying an inherently fireproof product, substituting a safer alternative flame retardant, or redesigning a product are possible ways to achieve code requirements without adding toxic substances.

To protect health while providing fire safety for the occupants of a building, the Perkins+Will report recommends that designers refrain from specifying products with added flame retardants whenever possible. The report also provides simple guidelines to help determine which flame retardants are more likely to be potentially problematic from a health perspective:

- Halogens, which includes bromines and chlorines, are the most toxic and persistent;
- Organophosphorus, apparently not as bioaccumulative or ecologically persistent, with health effects relatively unknown;
- Mineral/amine/salt types, which are currently the safest in terms of human and ecological health.

It is important to note that in the absence of comprehensive health and exposure data, regrettable substitutions (substituting a known hazard for something else that is later discovered to be as bad or worse in health or ecological effects) may occur. We have found that the precautionary principle—an approach to risk management that states that if an action or policy has a suspected risk of causing harm to the public or to the environment, then the burden of proof that it is not harmful falls on those taking an action—is helpful when weighing pros and cons of new materials or ingredients we may not be familiar with. In this case, the molecular structure of organophosphorus is very similar to halogenated flame retardants, and for that reason can be expected to act in similar ways. So even though there is not definitive health information about this substance, the precautionary principle would suggest to continue looking for other alternatives, even while some manufacturers are promoting organophosphorus as a safer alternative to halogenated flame retardants.

Building owners, facility managers, and the design team need to be aware of the concerns, challenges, and opportunities around the de-specification of halogenated, brominated, and organophosphorus flame retardants. With a fully educated and engaged project team, alternatives can efficiently be researched and applied.

The architect and interior designer can play the key role of educators in this regard. As team leaders they can:

- Open the discussion regarding healthy materials and exposure to flame retardants.
- Identify and help prioritize the products that can be replaced with alternatives.
- Prioritize products occurring in the largest quantity or in the most direct contact with the occupied space for further research when preferable alternatives aren’t readily available or feasible.
- Include language in specifications that allows non-flame retardant products, so alternatives are not unintentionally barred from the project.

Building owners can include similar language within their design and procurement standards.

It is also critical for the construction team to be part of the education process, including administrators and other team members that may have been far removed from the early days of the project. It’s important for those who process submittals and are the gatekeepers of products that actually arrive on site to learn what is acceptable for the project.

This effort ties in with the recent movement of material transparency. Flame retardant information is often unavailable as general information about a product. There are only three manufacturers in the world who supply the chemical flame retardant substances, and that has led to much secrecy regarding their compositions. It is imperative that design professionals request information regarding the types of flame retardants from product manufacturers with the aim of encouraging greater transparency and material disclosure. In order to be successful, the industry needs to work collaboratively—market transformation will not occur without manufacturers and their supply chains working diligently toward the shared goal of healthy, non-toxic buildings.

The good news is that regulatory drivers are starting to change. California’s TB117 was recently revised, and along with a companion labeling law, it is now possible to specify upholstered furniture without added flame retardants and be assured that the product that shows up on site actually complies. There are also ongoing efforts to reduce and eliminate unnecessary flame retardant additives in consumer electronic products, as well as changing the uniform building codes around insulation. Contact your local industry group chapters to find out what efforts are underway in your area, and learn how you can get involved.
SOURCES:


2 http://media.apps.chicagotribune.com/flames/index.html


FURTHER RESOURCES:

transparency.perkinswill.com
Healthy Building Network
Safer Insulation Solution
Green Science Policy Institute
Center for Environmental Health

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More than 20 years ago, upon entering the professional interior design world, ready to make a difference in healthcare design, I was quickly disheartened by the larger profession. It’s important to understand that interior designers are not solely focused on adorning spaces with finishes and decoration; rather, we holistically, thoughtfully, and responsibly create space. We weave together the technical with the aesthetic. Our passion is to improve the quality of life and human experience, and ultimately we are responsible for the health and well being of all.

While much regarding our profession has changed for the better over the past 25 years—with advances in research demonstrating the impact of the environment on project outcomes—designers still struggle with misguided public perceptions that confuse decorating with design. Despite these challenges, universities are now offering exciting new education options that result in more technical knowledge and professional credibility.

**Interior design education**
My bachelor’s degree in interior design prepared me well for what I truly wanted to do: create interior space. Surprisingly, what I was taught in school didn’t exactly align with what interior designers were actually doing in my city at the time. I discovered that, to get the type of opportunities I wanted, a master’s degree in architecture was essential. Within five years of graduation, I went back to school.

In recent history, some interior design schools came to a consensus to create more education options for healthcare specialties by offering additional certificates and degrees. Two examples of such programs are Stephen F. Austin’s online Master in Healthcare Interior Design and New York School of Interior Design’s (NYSID) Master of Professional...
Studies (MPS) in Healthcare. NYSID Healthcare MPS Program Director, Victor Dadras, notes that feedback from professionals and students were the impetus for the new healthcare graduate program and that, unlike architecture programs, this program connects research to design. Dadras point out that the multiple classes collaborate each semester with shared goals, such as improved patient outcomes and infection control. “When the MPS program in healthcare interior design was offered at NYSID, I couldn’t apply fast enough…I’m definitely learning on the job every day, but the education I received from the program gave me a great foundation,” says Cassandra Ramirez, NYSID MPS HC graduate.

It is my sincere hope that specialized education programs like these examples will open the door to more interior designers as healthcare planners, a role typically exclusive to architects. Why alienate the particularly valuable interiors skill set, and give up the title of interior designer in order to plan interior spaces for health? We do not want those specialized in interior spaces to choose a different career path, but rather, to celebrate the role of the interior designer as a professional specialist.

**Interior design and public perception**

Despite the advancements in education options for interior designers, we as interior designers still struggle with a professional identity. As a case in point, just a few months ago The Huffington Post featured a scathing article about how interior design is an industry focused on style and cabinet design, citing state regulations and education to be arbitrary. Contract Editor in Chief John Czarnecki addressed this topic in his October 2014 editorial. It’s an unfortunate public perception of interior designers. Just yesterday, I heard a real estate broker cast doubt to a client regarding a square footage calculation “because she’s an interior designer.” The information was in fact correct despite the misjudgment by the broker.

Another architectural blogger argues that his experience with interior designers is favorable, yet in the same article states, “This mindset supports a perception that many architects have—that interior designers (rag pickers, paper hangers) don’t create space, they decorate it.” In my personal experience, this is not the case. Students in both colleges are taught to design based around a central...
idea, taking into consideration a complex series of factors surrounding the project. A colleague, who is more than ten years my junior, had a similar experience when her healthcare interior design class toured a New York architecture firm. The architect tour guide actually stated that other architects often call interior designers “swatch makers.” Like me, my colleague felt compelled to pursue a master’s degree in architecture.

Stereotypes for interior designers from “HGTV,” “Will & Grace” and “Designing Women” are not even close to the professional identity we want to portray. Inasmuch, public misjudgment does not come as a surprise. Perhaps, as a profession, we should take note of the approach of the American Institute of Architects: In 2000 a national ad campaign was launched to improve the public’s poor stereotypes of architects. Why not spend some of our professional organizations’ dues to take our message to the public? Future interior designers deserve a clear public identity.

The benefits
As the old saying goes, “Two heads are better than one.” With complex healthcare projects, large design teams with engineers, consultants, and equally large client teams are required. Project leaders can be our strongest advocates or obstacles when it comes to everyone on the team participating as equals. The team determines the potential of a design’s greatness, and how responsive and sensitive it is to the needs of the patients and caregivers.

Clients and consulting teams need to support and include more interior design skills for healthcare by advocating for a more inclusive culture where listening to other people and other ideas is the norm, and where great design is valued over doing things as they have always been done. Interior designers: Position yourself in the design team and embrace the responsibility as an expert, armed with the required technical know-how. Have the knowledge, courage, and passion to ask the questions and challenge the status quo within the spirit of great design. I am fortunate to work in a positive environment, with an inclusive firm. Still, as interior designers, we need to work to clarify who we are to the public and advocate for inclusion among design professionals.

Environmental design truly has psychological and behavioral impacts, and there is no place more important for great design than the stressful, life-in-balance world of healthcare. The friendships with nurses and physicians and the thank you notes from the parents make healthcare interior design an incredibly rewarding profession.

SOURCES/CITATION


Brenda Byrd, IIDA, LEED AP BD+C, is a senior healthcare planner at Perkins+Will in New York. Additionally, she is a faculty member at New York School of Interior Design, the number one ranked graduate interior design school, teaching Programming for Healthcare Environments. As an advocate for excellence in integrated design teams, Byrd’s success is evident in a number of large hospital projects, including the Einstein Medical Center Montgomery in Pennsylvania and the Johns Hopkins Hospital Charlotte R. Bloomberg Children’s Center and Sheikh Zayed Tower in Maryland. She can be reached at brenda.byrd@perkinswill.com.
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