AAH1905: Medical Equipment Planning for Healthcare Facilities
Speaker Questions – Compiled and Answered

Q: Where can I find a copy of the presentation?
A: You may download a PDF of the presentation at http://bit.ly/AAH1905

Q: Where can I find a recording of the webinar?
A: All recent AAH webinars, including this one, are available to stream on the AAH Vimeo channel: https://vimeo.com/channels/1248268

Q: RE your first slide can you please clarify if the percentage of med equip cost you note is (as slide said) of PROJECT cost or as you stated, CONSTRUCTION cost. We know it's a big difference.
A: It should be construction cost. That is a typo.

Q: Should the responsibilities of a medical planner also include procurement and installation?
A: Ideally yes because it adds value to the project with continuous coordination during the procurement process. But practically, depending upon the Owner it can be separated out and Owner can be responsible for procurement.

Q: How does one balance the desire to delay acquisition of major fixed equipment with the need to have the structure and services in place without compromising the construction schedule?
A: Great question. The users always have a "lean" on the type and vendor of equipment which they would like to see in their space. Your medical equipment planner should be adept at extracting that information from end users which can be used as basis of design. If the end-users make a left-turn from the basis of design, the team can analyze the cost of the change and present it to owner for making an informed decision.

Q: What group do Scrub sinks (fixtures) fit in?
A: Group 1 - since it is fixed to the walls.

Q: How is the internet of things influencing medical equipment planning? Is this call for a new skillset?
A: Great question. Internet of things could reduce/eliminate mundane tasks previously performed/compiled by caregivers, however, it increases burden on IT infrastructure. It enhances the task of Medical Equipment Planner by improving patient experience.

Q: How do you deal with a RFP having a poorly defined scope of work?
A: Great question. You always respond to the needs of the RFP even if it has poorly defined scope of work. Ideally, the respondent should include additional scope of work which might be missing or is deemed crucial by them with a fee for additional consideration - but sometimes that may be viewed negatively. In my opinion, a good Owner should/would recognize the value of the missing scope if presented in right spirit.

Q: Does not the Medical Equipment Planner provide a list to the Architect to include dimensions of each fixed and movable piece of equipment that can be included in Space Programming by the Architect during Programming?
A: If the Medical Equipment Planner is involved during the space programming phase, he/ she should be able to provide dimensional information for "space-hogging" equipment. Getting detailed information at that early in the project is very unusual but can be provided.

Q: Should the medical equipment consultant be able to confirm current utilization rates/volumes or provide benchmarks for the major pieces of imaging equipment?
A: Utilization rates vary depending upon the protocol utilized by each hospital/provider for each piece of imaging equipment. The Imaging equipment comes with standard protocol, but each hospital/provider can/will change/adopt protocols that suits them and their patient population. Hence it is difficult to get utilization rates on Imaging equipment. But the medical equipment consultant should be able to provide ROI on the Imaging Equipment.

Q: Is the medical planner ALWAYS responsible for procurement or is it a mix most of the time between the planner and the owner's own purchasing agent? How would the work be coordinated and what would the architect's responsibility be between those two entities?
A: Medical Planner is NOT ALWAYS responsible for procurement, it is usually a mix. Ideally, there are benefits to medical equipment planner doing procurement because it adds value to the project with continuous coordination during the process and there is one-point contact for all changes which occur in the project - drawings and list. When working with Owner's procurement agent, the architect's risk and engagement increases since they must unravel the effects of procurement decision which are different from the basis of design on a timely basis.

Q: What is the "best" strategy for the architect completing the documentation for minimizing change orders when the users will not make a decision until the last responsible moment? or the equipment model is now discontinued?
A: Great question. The users always have a "lean" on the type and vendor of equipment which they would like to see in their space. Your medical equipment planner should be adept at extracting that information from end users which can be used as basis of design. If the end-users make a left-turn from the basis of design, the team can analyze the cost of the change and present it to owner to make an informed decision.

Your medical equipment planner should be able to identify equipment which are discontinued early on and often during the design cycle to plan for the correct equipment.

Q: Is it advisable to purchase maintenance service while purchasing a major type 1 or 2 equipment item?
A: Typically, maintenance services agreement cannot be capitalized for any equipment according to general hospital finance rules.

Q: Do you include Nurse call systems in your equipment inventory?
A: Typically Nurse Call falls under Low-Voltage/Electrical Scope

Q: How often do you do room mock-ups where the mock-up room contains the medical equipment?
A: Typically, 10%-15% of the projects utilize mock-up with medical equipment.

Q: Are you seeing increased use of long-term lease agreements for major equipment?
A: We are seeing trends where long-term lease agreements are becoming obsolete. They are moving towards capital purchases so that they can depreciate the assets on their books which is not possible with long-term leases.

Q: Please repeat the 6 categories of medical equipment.
A: Primarily here are the major categories of medical equipment. Group 1 to Group 4 are typically in Medical Equipment Planner's scope.

- Group 1 – Fixed to Facility
- Group 2 – Moveable equipment with utility requirements
- Group 3 – Mobile equipment
- Group 4 – Instruments (noted as allowance)
- Group 5 – Furniture
- Group 6 – IT, Computers, Printers for business processing
- Group 7 – Technology, Security, Nurse Call, AV

Q: How are fees for medical equipment planners established? (I will need to have legal review this answer to make sure we are allowed to post this. We don't talk about fees.)
A: There are many metrics involved in establishing fees for a project, but complexity and size of a project will drive the fees. A single Hybrid OR will demand a higher fee versus a 10-bed ICU. You can reach out to me directly, if you are interested in seeking a quote on a new or ongoing project.

Q: Can you provide List of Furniture Groups?
A: Primarily here are the major categories of medical equipment. Group 1 to Group 4 are typically in Medical Equipment Planner's scope.

- Group 1 – Fixed to Facility
- Group 2 – Moveable equipment with utility requirements
- Group 3 – Mobile equipment
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Q: What is your opinion of use of integrated OR ceilings?
A: They are a great solution provided the project can afford a high capital outlay compared to stick-build option. The added advantage would be to reduce the construction time especially when you have more than 6 ORs - you can shave off couple of months on your construction schedule. There is long-term benefit for Engineering departments with this solution, but your engineer can discuss the pro/cons of this system.

Q: What are some other examples of central repositories? aside from Attainia, is Drofus another database? what others are common?
A: Attainia has the biggest market share in USA. Drofus is mostly popular in Europe and Middle East but have not seen a lot of traction in USA. There are some startups in development but Attainia has a lot of years over them.

Q: What is the typical fee structure for a medical equipment planner?
A: There are many metrics involved in the establishing fees for a project, but complexity and size of the project will drive the fees. As single Hybrid OR will demand a higher fee versus a 10-bed ICU. You can reach out to me directly, if you are interested in seeking a quote on a new or ongoing project.

Q: How do you derive the equipment list codes when producing the room by room list ?
A: Equipment List codes are standardized. Primarily here are the major categories of medical equipment. Group 1 to Group 4 are typically in Medical Equipment Planner's scope.

- Group 1 – Fixed to Facility
- Group 2 – Moveable equipment with utility requirements
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Q: What kind of medical equipment technology is currently undergoing the most evolution?
A: OR Integration is always under constant evolution along with software tools which are available for different imaging modalities. There are some changes in Cardiology Imaging Equipment and MRI has some incremental changes.

Q: Is there a trend to have M.E.P. brought into the project before the A/E?
A: Rarely, only if there a need to get your arms around equipment cost for equipment intensive area like ORs (greater than 8) and Interventional areas.