

**CAPITAL PROJECTS ADVISORY REVIEW BOARD  
PROJECT REVIEW COMMITTEE (PANEL REVIEW)**

**Northwest Carpenters Facility  
25120 Pacific Highway South**

**Kent, Washington  
September 24, 2015**

**9:00 AM**

**Minutes**

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**PANEL MEMBERS PRESENT**

Curt Gimmestad, (Chair), Absher Construction  
Ato Apiafi, ATO Apiafi Architects  
Steve Crawford, Issaquah School District  
Chuck Davis, Seattle Central College

Tim Graybeal, Integrus Architecture  
Shasta McKinley, Civil & Environmental Consultants  
Rob Warnaca, Mortenson Construction

**STAFF, GUESTS, PRESENTERS**

Jeff Jurgensen, OAC Services  
Shane McGuire, Columbia County Health System  
Graehm Wallace, Perkins Coie  
Tom Gow, Puget Sound Meeting Services

Randy Barber, OAC Services  
John McLean, Blue Room Architecture  
Danelle Bessett, DES

**Welcome & Introductions**

Chair Curt Gimmestad called the CPARB Capital Projects Committee Panel meeting to order at 9:03 a.m. Panel members provided self-introductions.

**Public Comments**

There were no public comments.

**Panel Review – Dayton Community Hospital – GC/CM – Modernization & Expansion Project**

Panel Chair Gimmestad reviewed the presentation format. Panel members included Shasta McKinley, Chuck Davis, Tim Graybeal, Robert Warnaca, and Ato Apiafi.

Jeff Jurgensen, Program Manager, OAC Services Inc., reported the proposal is from Dayton Community Hospital. The presentation will cover the project scope and demonstrate why the General Contractor/Construction Manager (GC/CM) delivery method was selected for the project.

Shane McGuire, Chief Operating Officer, Columbia County Health System, reported Dayton Community Hospital is a small critical access hospital in eastern Washington located in one of the 1960s buildings constructed under the Hill-Burton Act. The hospital has had no appreciable changes to the original building. The main hospital was built in 1964 and the annex was constructed in 1969. Since then, some mechanical upgrades have been completed, but no large wholesale changes. The last large project was completed in 1990 to add a 39-bed nursing home, which was considered a free-standing construction project.

Mr. McGuire said his experience includes oversight of some minor projects involving the 1,200 square foot modification of the emergency room to include the addition of a CT scanner. Challenges the hospital faces are the uncertainties surrounding existing building infrastructure and securing contractors to work in a rural environment in eastern Washington.

The owner acknowledged the aging of the facility and the need to reinvestment. Last year, the owner reviewed business operations and the physical design of the hospital, which was initially designed as an inpatient hospital during an era where there were two patients in each room, heart surgery required a week stay, and minor surgery required a several-day stay. Today, 90% of the hospital's business is primarily outpatient care with over 30,000 lab procedures performed annually and 140 emergency room visits a month. For a small rural hospital, those numbers are significant. The hospital is experiencing four-year highs for lab radiology and ER services. The hospital is currently constrained by the environment.

The owners developed some plans to reshape the interior of the building without affecting the external structure of the building to produce an outpatient setting. Some design elements were developed and the hospital outreached to the public by seeking a bond measure to fund construction. During the process, hospital officials determined the typical Design-Bid-Build delivery method presented some challenges and concerns. The hospital had previously completed some low bid projects. The CT project came in \$100,000 over budget after the discovery of required additional infrastructure work once the floor was opened. The project was completed on a change order basis. The project scope was less than 1,000 square feet and exceeded the budget by over \$100,000 in additional project costs. Subsequently, hospital officials were concerned about implementation of the proposed project.

The project architect advised hospital officials of the GC/CM delivery method. Mr. McGuire said he's also signed up for GC/CM training and is currently on the waiting list. During research on the delivery method, several names were consistently identified as specialists in GC/CM. He contacted those individuals and began building a team to complete the project under the GC/CM delivery method with assurance that the team has the required experience.

Mr. McGuire introduced Graehm Wallace, Attorney, Perkins Coie. Mr. Wallace said he's a partner in Perkins Coie and was retained to assist the hospital with the construction contracts for GC/CM rather than Design-Bid-Build (D-B-B). He has nearly 20 years experience in GC/CM projects. Prior to working for Perkins Coie, he represented contractors and subcontractors and brings that experience to the project and considers the approach from the perspective of contractors and subcontractors. Mr. Wallace advised that the project would move forward out of necessity to upgrade the hospital. The question is whether the panel approves the hospital's request to complete the project under the GC/CM delivery method or under the D-B-B model. The hospital is an occupied facility with patients. The importance of having an experienced team is paramount to ensure the hospital continues to function. It's important a team member is a GC/CM contractor to work with the hospital through design and planning rather than exposing the hospital and its patients to risks by securing the services of a low bid contractor.

Team members Jeff Jurgensen, Program Manager, OAC Services, and Randy Barber, Principal-in-Charge, OAC Services provided self-introductions.

Mr. Jurgensen reported the phasing documents were completed by another designer and are not cast in stone.

Mr. McGuire said the areas for remodeling actively serve patients on a daily basis. The hospital has three emergency rooms, a lab, and one radiology department. During the prior ER project, it wasn't possible to shut down trauma areas. The nature of services provided by the hospital includes ER patients who typically are outpatients rather than an ER patient. The hospital is located 20 miles from a ski area. During hunting season, the region attracts thousands of hunters each year, and during the summer season, visitors come to the area to participate in water sports on the river. Introducing trauma patients to an area under construction is not optimal for treatment, which speaks to the importance of phasing the project to ensure impacts do not occur to trauma patients while also accommodating construction. The hospital is a 24-hour year-round facility. Many

of the areas to be remodeled are actively used. Additionally, the hospital is experiencing an increase in patient volumes. The right contractor is essential from the beginning to determine phasing of the project while continuing to provide life-saving services in a rural community. The closest medical facility is located 35 miles from the hospital. During the winter, that drive exposes too many risks to individuals who may be suffering from a ski injury. Project phasing is a critical component for the success of the project.

Mr. McGuire reviewed information on the phasing steps for specific areas of the hospital. Most of the areas under construction are in core service areas rather than laundry, dietary facilities, or long-term care areas. Physical therapy is the one exception that is not provided on an emergency basis, but it's one of the highest volume departments in the facility performing approximately 2,800 procedures monthly.

Mr. McGuire reviewed additional potential phasing slides of the intake areas, emergency rooms, and public access entrances. Because of the length of time required for the intake of ER patients, the ER will be moved to the front of the building.

Under RCW 39.10, the project meets four of the criteria. The project includes complex scheduling and phasing because many of the services offered are patient-impacting services. The facility is busy and occupied with 130 full-time employees. The ER, Radiology Department, and the Lab are open 24 hours a day. Phasing will include walling off certain areas with construction activities occurring in close proximity to medical procedures. The potential to maintain the environment is great with construction activity sometimes ceasing dependent upon the medical situation. The facility is a technical environment ranging from pharmacy controls, infection control processes and procedures, and negative and positive air intake/outtake processes. The end result of the project is also complicated, as the project requires a successful beginning and an end.

The involvement of the GC/CM in the design stage is important at the beginning to identify all complexities before they become crisis situations during construction. The nature of the business requires identification of all the environmental variables that could impact patient outcomes.

The hospital completed selection of the architect through a Request for Qualification process. John McLean, Principal, Blue Room Architecture, is the architect for the project. OAC Services was contracted to provide GC/CM expertise in project management and project application submission. The intent is selecting the general contractor in the December timeframe dependent upon the initial design process. The goal is involving the GC/CM as soon as possible to provide as much input into the development of the construction documents.

Mr. McLean reported that predesign was recently completed. Blue Room Architecture specializes in critical access for rural hospitals. The design is entering the schematic design phase, which is an opportune time to include the general contractor to assist in integrating the project phases.

Mr. McGuire said the hospital was fortunate in the ER project to locate a contractor who assumed a partnership role in the project introducing the potential of what a partner-general contractor could lend to the project. The project also encountered a negative experience when issues during construction necessitated change orders resulting in cost overruns. Under the low bid scenarios, many contractors submitting low bids were out-of-state contractors. Once the project was completed, those contractors were no longer available creating a difficult situation of securing their service to complete warranty work.

Mr. McGuire shared information on the passage of the bond. At one point, the measure was one vote behind to attain a 60.02% super majority required for passage. Multiple recounts of the ballots were necessary with the results revealing the bond passed by two votes. The community is engaged in the project. It's important to present an organized project when the community questions the process.

Mr. McGuire reviewed the estimated project budget. Should the project need to pursue a D-B-B delivery method, hospital officials likely would need to reconsider the scope of phasing, as more contingency funds would need to be allocated.

Panel Chair Gimmestad invited questions from the panel.

Ato Apiafi asked about the percentage of the contingency amount in the budget. Mr. McLean said the budget includes a 5% contingency based on the GC/CM delivery method. If the project were completed by the low bid method, a 15% contingency would be anticipated. Mr. McGuire said the 5% contingency was based on prior completed projects. Assuming the right partners are involved in the project, the hospital believes the budget can be maintained by phasing.

Tim Graybeal thanked the project team for a good presentation that was well stated. The reason for the preferred selection of GC/CM is the primary reason why the statute was created as it recognizes that there are certain situations where it's critical to have a full team at the onset of the project to solve many of the issues, particularly in a hospital setting where the owner hasn't completed many construction projects of a similar magnitude. Having a project team with expertise will help the hospital substantially. He asked about the owner's expectations in terms of what should be included in the budget to afford the project team expertise. Mr. McGuire said the budget was frontloaded with the cost of the GC/CM oversight to ensure the right team was selected. Having the right contractor at the onset minimizes oversight needs during construction. Although the project is a major one for the hospital, it's not a large project and by having the right contractor, it likely would not entail having the contractor available 100% of the time. It's important to have communication and the availability of the project manager during construction.

Chuck Davis referred to the comments about the difficulty of attracting good contractors because of the remoteness of the location. He asked about the GC/CM contractor pool that might be interested in bidding on the project. Mr. McGuire cited a recent school project completed by a GC/CM. A contractor in Sunnyside has expressed interest in the project, as well as another contracting firm in Spokane with school project and private hospital experience. All the contractors are familiar with the GC/CM delivery method. It's anticipated approximately three to five general contractors will compete for the project. Five general contractors expressed interest in the hospital's prior ER project.

Mr. Davis asked whether OAC Services has had any discussions with GC/CM contractors. Mr. Barber said the pool of contractors is located in the Yakima valley, Tri-Cities area, and the Spokane area. The project is attractive because of the importance to the community and because many contractors prefer to work on small hospital projects.

Mr. McLean added that five contractor inquiries were received for the project. Three of the contractors are familiar with the facility. Most of the interest has been from companies located in the Walla Walla/Tri-Cities market, as well as Yakima and Spokane markets. The project has also received inquiries from the Seattle marketplace. Information conveyed to the Seattle marketplace emphasized the need for the customer to receive ongoing support and quick response times because of potential emergencies that must be addressed, as well as warranty support following the project. All contractors are expected to respond to those requirements as part of the qualifications.

Mr. Jurgensen said the subcontracting community would likely require some encouragement to work on the project when similar work is available in Spokane and in other areas. The GC/CM will be relied on not only for their expertise, but also for their relationships within the subcontracting community.

Mr. Wallace said the proposal is a request for approval to seek a GC/CM contractor. If the application is approved, the owner is prepared to undertake the process to solicit a GC/CM contractor. Should the owner encounter difficulties and learn that there are no good qualified GC/CM general contractors bidding on the project, the owner has the option to pursue D-B-B. However, the request is for the PRC to afford an opportunity to the owner to search for the appropriate contractor.

Robert Warnaca said the presentation did a good job of illustrating why the project is in need of a GC/CM delivery model given the need to avoid disruptions and having a basic understanding of the aged infrastructure constructed in 1960s. However, the application was unclear in terms of management in the day-to-day interaction between the hospital, GC/CM, and the architect. It's important to ensure the GC/CM is successful by bringing those with the expertise together and allowing the GC/CM access into the facility to complete third party surveys and providing reports especially given the different geographic locations of the different entities. He asked about the identification of the point person that will manage that process. Mr. Jurgensen indicated and he and McGuire would jointly provide the necessary oversight.

Mr. McGuire said based on his prior experience at the hospital in the upgrades for the CT and the Radiology units, he gained valuable experience in coordinating multiple contractors and timelines. Since the Board has directed that the project is the hospital's priority, it will free up his time to focus on the project to ensure its success.

Mr. Davis recalled his previous work in public hospitals and a board that would never entertain an alternative delivery method for any project. He asked whether there is any anticipation by the owner that the GC/CM delivery method will save money. Mr. McGuire affirmed the delivery method would save costs based on previous experience because once hospital areas are dismantled many unpredictable issues occur. Having the right GC/CM contractor in place without undertaking the negotiation of a change order situation will be very helpful for the project. Change orders, even in smaller projects, can add up very quickly.

Mr. Davis asked about OAC Services' experience regarding the differences in cost of GC/CM versus D-B-B. He asked whether any negatives might suggest GC/CM would save costs or whether the primary reason for the alternative delivery is to reduce risks. Mr. Barber said because the intent of the owner to mitigate the risk at the beginning, the GC/CM delivery method is a most cost effective way to deliver the project.

Mr. McGuire added that risks and costs are another component from unforeseen issues during construction, as well as a lack of coordination. There is a real cost that can be assessed to the hospital if the CT scanner or the Radiology unit is not available. The risk can be quantitative in a monetary figure, as well as in a healthier delivery perspective. When the hospital considers risk, it's not just the risk of contractor change orders, but rather the costs in the services offered to the community.

Mr. Davis emphasized that GC/CM is likely the only method that healthcare should be using exclusively. The issue is whether the hospital is prepared and able to use the delivery model successfully. A number of GC/CM projects have not been successful across the state. GC/CM is not a panacea leading to some concerns in terms of the organizational chart that reflects that approximately 45% of time, no one on the project would have GC/CM experience. He cautioned the team that GC/CM is not an easy method to use because it requires much oversight. He suggested the team might want to reconsider how much additional project management is necessary.

Mr. Barber responded that the company is built on providing customer service and OAC will respond to the owner's needs. The goal is to ensure the project has a good qualified GC/CM. Based on previous experience, diligent and carefulness in the selection will reduce the amount of time necessary on the site. However, older

buildings can produce surprises when walls are opened. OAC Services is willing, ready, and capable to spend more time.

Mr. Davis acknowledged the reputation of OAC and expressed confidence the company would not let the owner fail. However, the budget appears to be underfunded from a project management perspective.

Mr. Apiafi pointed out that no one wants to be identified with failure. The risk falls to the general contractor as an experienced GC/CM who is one leg of the three-legged stool affording the owner a better opportunity to be successful.

Mr. McGuire commented on previous successes by the owner to develop teams. OAC Services and Perkins Coie are the beginning of the "A" team with one missing leg, the GC/CM. He is extremely confident that a good GC/CM will be hired.

Mr. Wallace acknowledged that the project has risks. The project is in a 24-hour operating environment located in a rural area where patients can't be turned away. The question is which method is riskier – GC/CM or D-B-B. Of the six criteria, the project has met four criteria. The question is which method has the best chance for success. Is the GC/CM method guaranteed to bring the project to conclusion on time and within budget? No, it's not; however, it has a better chance of mitigating risks along the way to achieve a better outcome than D-B-B.

Panel Chair Gimmestad invited public comments. There were no public comments.

Panel Chair Gimmestad closed public comments and invited the panel's deliberations.

Mr. Graybeal agreed with Mr. Wallace that the project is perfect for GC/CM. His main concern centers on the funding for the project and the necessary quality oversight from the contract manager's perspective. The delivery method is in a sense, an insurance policy by adding additional owner oversight. He also fears that the budget is underfunded for onsite services. However, that is the responsibility of the owner rather than a PRC member by not allowing the owner an opportunity to complete the project using GC/CM.

Shasta McKinley said it appears the owner has researched the delivery method and it appears the budget attempts to accommodate a construction manager's oversight. The presentation by Mr. McGuire reflects he has done a good job of coordinating the team.

Mr. Crawford acknowledged that the location of the hospital in Dayton presents a challenge, but was surprised that Mr. McGuire has as much as experience and involvement in projects and a good understanding of the process. The project is well suited to GC/CM because it's the least risky of the options available. The project qualifies because of the location and the inherent challenges of the location. Bringing a GC/CM to the project will help to develop a project that fits within the budget to avoid the situation of designing a project only to find that variances are necessary. The project is well suited to the uses of electronic communication tools to help bridge some of the gaps. With the challenges associated with a 55-year old bunker building and hospital services, the owner could have considered building a new structure.

Mr. Davis said healthcare projects demand the use of GC/CM. The project meets many of the criteria. The hospital operates 24 hours and cannot close. He supports approval of the application.

Mr. Apiafi spoke to the challenges associated with a hospital project creating noise, dust, and vibration. The owner must contend with the budget and the contingency; however, he's supportive of the application because

of the complexity of the project. It appears that the team has addressed the issues and concerns raised by the panel by employing a company with good GC/CM experience. OAC Services has a wealth of experience in this line of work. He looks forward to a successful project.

Panel Chair Gimmestad closed deliberations.

*All panel members voted in favor of the project application from Dayton Community Hospital for GC/CM delivery of the Modernization and Expansion Project.*

**Adjournment**

**With there being no further business, Chair Gimmestad adjourned the meeting at 9:49 a.m.**

Prepared by Valerie L. Gow, Recording Secretary/President  
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