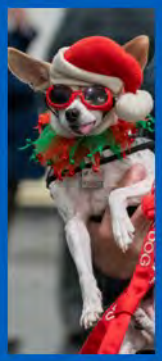

Executive Summary

5th Atlanta

Hospital, Outpatient Facilities & Medical Office Buildings Summit

December 3, 2025

Future of Healthcare Facilities

Tackling Aging Infrastructure & Supporting New Delivery Models

Planning, Real Estate, Design, Construction, and Operation of
Hospitals | Clinics | ASCs | MOBs | Retail | Telehealth
Home Health | Non-Clinical | Research Facilities

This Education and Networking Event is Presented by
Corporate Realty, Design & Management Institute
Association of Medical Facility Professionals
National, Regional & Local Sponsors

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Executive Summary:

- Looking Ahead: Healthcare Industry Outlook 2026 and Beyond
- Security in an Era of Increased Violence
- Designing Sliding Doors for Space Savings and Optimization
- Clean Air and Air Filtration System Solutions
- Great Design Matters to the Bottomline!
- Solving the Parking Puzzle
- Using Cleanroom Technology to Improve Critical Environments in Healthcare
- Navigating the Annual Budget Process
- Making Hospital Rooms Smart
- Integrating Behavioral Health Care and Medical Facilities
- Backfilling Hospital Space: Opportunities and Challenges

This executive summary was written by Mary Loftus, Editor, Emory Health Digest

Corporate Realty, Design & Management Institute, AMFP, and AMFP Atlanta want to thank these sponsors for making this educational and networking program possible.

Looking Ahead: Healthcare Industry Outlook 2026 and Beyond

Laura Gurley, Healthcare Strategy Associate, DPR Construction

Carl Fleming, Healthcare Strategy and Digital Transformation, DPR Construction

Water is getting a little choppy.

- National consumer confidence is a mixed bag. It's lower than during the Great Recession and during the entirety of the pandemic.
- Consumers are wary about inflation, job expectations, and personal finances. They spend a lot of time thinking about money (four hours a day).
- 18- to 34-year-olds believe there is a large risk of losing their job over the next five years. Top of mind.
- The GDP went down during the first quarter then increased the second. A mixed picture.
- Unemployment on the rise from the beginning of the year. Not sure of recent numbers, delay in data because of government shutdown. US jobless rate 4.4 % as of September. Inflation rate, 3 percent.
- Impact Georgia? Of states at risk of or in recession, Georgia is on list. Three main factors: increasing tariffs, slowing immigration (hot spot for ICE raids), federal job cuts (Department of Health and Human Services cuts, CDC based in Atlanta). Job openings, GA employment rates better than US as whole but starting to decline a bit.
- Cuts are going to impact health systems. What are healthy systems doing to prepare? Capital and scenario planning, revenue loss mitigation strategies, cost containment and efficiency, workforce and access management.
- Cost of goods rising every year. Big impact on consumer confidence.
- Construction activity, nationally still rising but rate has decreased. Georgia saw a contraction in non-residential construction.
- What are economists saying? Some believe a recession is coming. Consensus: the "lights are not necessarily flashing red" but the economy is "soggy, soft, weak but not collapsing."

A lot on the table for cuts.

- Cuts are going to impact health systems. What are healthy systems doing to prepare? Capital and scenario planning, revenue loss mitigation strategies, cost containment and efficiency, workforce and access management.
- Once the "Big Beautiful Bill" passed in July, there were big impacts in terms of cuts to federal health insurance programs. Medicaid and marketplace, ACA subsidies expiring, reason for government shutdown. End result: no resolution, another vote.
- Individuals are going to see health insurance premiums rise. Medicare will have some increases and some decreases. How does this impact Georgia? More than 750,000 Georgians are expected to lose health insurance.

- Of rural hospitals in Georgia, nine are at immediate risk of closure. These will be more deeply impacted by cuts because they are already on brink of closure. Provider tax freezes, seeing some go away, hospitals have to come up with funding. Medicaid work and eligibility, lose care because of work requirements. Almost half children in state of Georgia, 1,779,000 children, are on CHIP, which will impact pediatric providers.
- Cuts are going to impact health systems. Revenue loss estimated to have a $170 million impact, according to a study by the Advisory Board. Already seen some of the impact, with research grants being cancelled.
- What are healthy systems doing to prepare? Capital and scenario planning, revenue loss mitigation strategies, cost containment and efficiency, workforce and access management.
- A fourth have paused capital investments. Almost all foresee buying less equipment, delaying upgrades, and reducing supply budgets temporarily or long term. Operating costs down; cost containment and efficiency up. Increase stockpiles, some layoffs (cut administrative costs so more can go directly to patient care.)
- Hospitals clawed back margins from their lowest point in 2022. Operating margins remain stable, but there is a wide gap in performance. Revenue has increased but margins have decreased. National inpatient volumes are forecast to grow again. A big part in the increase is in labor cost, nationally, but specifically in the South. Labor expenses big issue over past few years.
- We need to come up with more unique solutions to help our health systems stay afloat during this time.

Sustained workforce challenges.

- Georgia ranks 40th among all states in the ratio of active patient care physicians to the population, with 1 physician for every 480 people. The state is projected to be short more than 8,000 doctors. This is 23% worse that the national average. There are only 167 resident slots in Georgia for primary care each year, and 33% of these residents will practice in the state.
- Impacts on physicians attributed to the shortage include: feelings of overwork or burnout by physicians; diminished job satisfaction; negative or deteriorating workplace culture; thoughts of leaving clinical practice, concerns about medical errors, unsustainable patient caseload; unsustainable work hours; inability or limited ability to accept new patients; outbursts or threats from patients; anxiety or depression.
- Currently Georgia is the largest state with just one public medical college, although new ones are being built.
- Lower income folks in the state are the ones who are going to suffer disproportionately. As supply falls, patients wait longer to see a doctor and doctors

burn out. Shortage for mental health professionals are even more dire, as the need is increasing.

- The good news is that, from a physician perspective, we are starting to turn the corner. Health systems and teams are adapting and adopting technology, ambient clinical intelligence is capturing relevant clinical information and putting it into the system, all to create new patient care experiences and encounters. In the exam room and inpatient setting, talking and typing is going away, becoming more of a conversation and dialogue.
- Will this change way we design and build? Yes. Physicians on board, although we are not quite there on nursing side. There are already not enough nurses, and the average age is 50s. As we design and build and execute projects, we need to bring these voices in to be successful.
- While RN vacancy and turnover rates are slightly down, 63% of RNs report being assigned too many patients at a time; 76% say they experienced burnout in 2023; 62% say workload has increased since 2020.

Demographic reality.

- A new generation is in town, Gen Beta, which will inherit a world facing climate changes and rapid urbanization. Physical and digital life intertwined and seamless. AI and automation will be fully embedded from education and workplaces to healthcare and entertainment. They will make up 18% of the global population by 2050. Their parents will prioritize adaptability, equality, and eco-consciousness. Sustainability will be an expectation. Digital interaction is the default.
- The six generations: the Silents (85+), Baby Boomers (66 to 84), Gen X (50 to 65), Millennials (34 to 49), Gen Z (21 to 33), and Gen Alpha (5 to 20).
- Age 65 and older is the largest growing segment of the population in greater Atlanta. They aren't moving to midtown, but to suburbs outside the perimeter.
- Domestic migration has always been big in Atlanta, during COVID it exploded. International migration, however, has slowed. It has not been at the pace of previous years.
- Over the next 25 years, the population of Metro Atlanta's 21 counties will grow from about 5.7 million in 2015 to about 8.6 million in 2050.
- Outer ring counties, newcomers are moving from Florida, California, Texas, New York. Fulton and Gwinnett continue to grow. There is a strong outpatient growth forecast, as the population is aging, and the acute side is getting more acute.
- Each cohort wishes to receive healthcare differently: digitally connected, they might read a review online to decide where to go. Older, they would ask a family member. Aging population avoids travel, don't want to come to city center for care. How do we get healthcare closer to home, or even at home. Expand services in neighborhoods.

Phygital environments.

- Healthcare's hybrid future will be a blending of physical with digital healthcare environments. The shift to hybrid is here already and is going to transform care delivery.
- The industry faces an imperative: transform spaces or risk falling behind in adapting to the new care models that no longer adhere to the constraints of physical walls.
- Ambient clinical intelligence will change how interactions occur. Delivery continues to shift toward seamless, continuous, and hybrid. Health care is no longer bound by the four walls.
- External forces are reshaping when, where and how care is delivered. Ambient technologies are a big part of that.
- Progressive healthcare systems in town are already adapting, adopting, and accommodating. They are moving from traditional room-centric design to patient-centric.
- What does the hospital room of the future need to be? Pervasive but not intrusive. We are talking about care models that haven't even been invented yet. We must build platforms that can adjust and shift according to patient need and technologies, not just places.
- Design for adaptability. More robust IDFs. Supplemental cooling (pumping a lot more power and processing through those spaces, which generates heat).
- Implementing on-device AI boosts reliability, privacy, and speed while erasing the infrastructure load.
- Why would a CFO want to invest in phygital? Strategic advantage. When you plan a building that can adapt, adopt, and flex, it doesn't have to be replaced as quickly.
- Think of AI as a collaborative partner, a design teammate instead of a tool.
- Planning needs to involve methodologies, how to maximize technologies and embrace an augmentation culture.
- Invest in AI literacy for your teams. Everybody needs to know. We're not just planning for the future; we have to plan for multiple futures. To embrace transformation means to elevate care.

Security in an Era of Increased Violence

Adrian Arriaga, Director, System Security Services, Children's Healthcare of Atlanta;

Ashley Ditta, 2026 President-Elect, IAHSS, and Public Safety and Parking Director, Newton-Wellesley Hospital;

Dan Yaross, 2026 President of IAHSS;

Melanie Wright, Regional Business Development Manager Healthcare, Assa Abloy.

Moderator: Bill Navejar, president, International Association for Healthcare Security and Safety (IAHSS) Foundation, Bill Navejar Consulting Services.

How important is design in creating and maintaining a safe environment for staff and patients?

Wright: It is the most important thing. I work in the specification arena, pulling together hardware sets. It's important to bring security to the table to have that conversation. Where to put card readers, for example. Not just that, design concepts. We apply the SEPTED model (a strategy using physical design and environmental management to reduce crime and fear by influencing behavior and focusing on natural surveillance, access control, territoriality, and maintenance). Coordination needs to begin in the design development phase; it costs more if things have to be retrofitted. To reinforce security and have the best in place, have these conversations early.

Ditta: From a practitioner's perspective in security, designer is imperative. Every layer – that's what security is, layers to reduce the risk. You need to plan things like separating waiting rooms from treatment areas and determining access to doors. Use SEPTED to designate and separate spaces. IAHSS guidelines are also important. As a practitioner, I'm visually oriented and need to see it.

Arriaga: It goes back to strategy and understanding an organization's goal. For example, a staging area in a behavioral health facility, if its design is "fluffy" it doesn't meet demands. Both risk and perception of risk need to be considered. Take into account the population being served and what is going on in the external environment. Is there a six-times higher rate for crime in this area? Build with that consideration, through a layered approach. If aesthetics is open and welcoming, it's harder to keep safe. If you want 400 cameras, great, but put them in place early on, or things will be in the way: signs, vegetation. It costs more money on the back end.

What are you setting up in a template for the future? Put the bones in place. Create efficiencies; reduce waste.

You have an upcoming construction project, and the team is in front of you, what should they know?

Yaross: I'll give an example of two different children's hospitals. One, it was great working with the facilities group. We ended up reporting to them. They had a well-established process to include security functions early into the conceptual phase of the project. The other was building a new 14- story inpatient tower, and there were zero security cameras in inpatient units. Most spaces were built out. Security cameras were only in elevator lobbies. We put in 360-degree cameras, which provide four views for the price of one camera. All hallways intersected, and the nursing station was where most problems occurred, so we placed cameras there in the ceiling. It was a good solution, but there was a lot of catching up to do because the security group wasn't invited to the table. Once we were, our projects became much more efficient and effective. Work with the end users to understand operationally how they view patient and workflow, and you can have an effective plan from the get-go.

Ditta: Most important for a construction team are the IAHHS design guidelines and other regulatory guidelines. There are new sections on outpatient, ambulatory, MOBs. A big piece is weapons detection and screening. Reexamine all areas. Some healthcare companies provide copies of their own guidelines and standards to the architects.

Arriaga: Security is keen on advancing opportunities, a layer approach, and the integration process. Who is leading the construction process, who are the integrators we're going to be using, and can we meet with them? What is the process of outpatient vs. inpatient vs. patient care? The minimum baseline for door readers and cameras? Understand budget for security efforts. We have great relationships with vendors of all sorts, which reduces bids and creates opportunities. What is the project scope, the population being served, and the risks associated. For example, a mother-baby unit is going to have a lot more restrictions than a general unit or food court. Over a three- to four-year project, things get outdated, new products come out. You don't want to go into an obsolete phase before the project is even complete.

Audience questions: What are the non-negotiables?

Yaross: We would start with a risk assessment. That's the first starting point for new construction or renovation. The highest construction cost are the highest risk areas.

Ditta: Risk assessment important, but what's the population and the area being serving? Tech and security layering might be different in each environment.

Arriaga: Look at integration across the whole system. How does it all communicate; how are you leveraging it all into a central platform? I know what I want, but I need to know how to present it to executive leadership.

Wright: How we power things, ethernet, flexible tech. There are a lot of ways to incorporate all these different systems into one.

Audience question: The future of tech, for patient, staff, and visitors, will it be more visible or invisible?

Yaross: Yes and no. There are advantages and disadvantages. Weapons screening, there are tons of different devices out there, and they are not all created equal. Some are made for large populations to be quickly processed through. That's not the right solution for, say, a pediatric behavioral health unit. If one will only catch guns, but all these knives are getting through, you've picked the wrong solution. We look at security culture. Many hospitals haven't implemented weapons screening yet because of perception. We want to stop a problem at the door before it gets up to the floor. Good control of entry points. Children's hospitals are more restrictive. Security training is for everyone's safety.

Ditta: Anything specially around tech, you have to consider the culture, it's very different each place. Boston, no one has weapon's protection. How do you not have this yet? If you match your culture to the tech, there are tough questions you have to ask. If your client doesn't like the way things look or are perceived, you're kind of sunk even if it works well.

Arriaga: Back to the design, it's a major consideration. How that environment looks when you are trying to walk in matters. You don't want weapons screenings slapped into spaces not designed for that, with tape all over the floor, not having been planned for, people trying to walk around it. How are you designing for flow? That should already be planned out.

Designing Sliding Doors for Space Savings and Optimization

Gene Jones, healthcare business leader, Allegion Healthcare

Sliding doors in healthcare facilities can do everything traditional swinging doors can do, and more:

- Optimize space, potentially increasing the number of exam rooms.
- Increase safety and comfort with advanced locking hardware and access control systems.
- Offer technical advancements such as doors with fire ratings, telescoping design, soft-close mechanisms, and vision control.
- Be made more affordable through group purchasing.

Case studies: Providence Health Gately-Ryan building in Renton, Wash., picked up three exam rooms, going from 33 to 36. • The University of Kentucky's Albert B. Chandler Hospital used sliding doors to lock and secure respite spaces, making them safe and secure. • Memorial Hermann Texas Medical Center in Houston uses a clear, 60-inch sliding door in the ICU to ease maintenance with breakaway doors.

Clean Air and Air Filtration System Solutions

Jason Cooper, Healthcare Segment Sales Manager, Camfil

In healthcare, details matter, and air filtration is no exception. The bottom line in healthcare is to measure what holds up, choose what stays stable, and invest in filtration that performs throughout its service life.

Here are a tip, a trick, and a trap for selecting air filters for healthcare settings:

- **TIP:** Always check the MERV-A rating, not just the MERV number. The difference is degrading versus non-degrading, which current standards require in a healthcare setting to protect patients, staff, and mechanical systems. Two filters can each say MERV 14, but only one may *stay* MERV 14 after real-world dust loading.
- **TRICK:** Don't select filters based on initial pressure drop — select for average pressure drop over the filter's life. A low initial pressure drop can be deceptive. Filters that start low but climb quickly drive up energy use, fan strain, and maintenance. A filter that stays stable preserves airflow, saves energy, and keeps systems operating as designed.
- **TRAP:** The lowest price filter is rarely the lowest cost overall. Cheaper filters lose efficiency or load quickly. The downstream costs, such as energy, labor, premature changeouts, and system stress, far exceed initial savings.

Great Design Matters to the Bottomline!

Callie Andrews, Senior VP and Market President, Wellstar North Fulton;

Amanda Mewborn, Associate Vice President, Planning, Design, Construction Infrastructure and Sustainability, Georgia Tech;

Donny Walker, Partner, Newcomb & Boyd

Moderator: B. Alan Whitson, RPA, Founder and President, Corporate Realty, Design and Management Institute.

To many, the phrase great design refers to visual appeal but it's much broader and deeper than that. Elaborate?

Andrews: So, why design matters. We had a big project, a patient bed tower at our flagship. Many buildings from 75 years ago were still on campus, we stress adaptability but also building things that last. Inter-connect ability is not only how things move through the building, but how things impact the usability of the campus. We involve end users; without them, we would inevitably miss things. Safety is important and so are aesthetics. You don't usually choose to come to the hospital, it's not usually joyful. Caregivers in hospitals just survived COVID; their days can be long and hard. A safe and healing place is paramount.

Mewborn: It's a privilege to be able to work in design in healthcare, on people's sometimes best (say, if they are having a baby) but mostly worst days of their lives. Yes, we want healthcare facilities to be beautiful, comfortable, functional, and efficient. Involving the frontline workers is very important, as well as mapping the experience of visitors and clinicians. Functionality based on what actually happens in the spaces we are designing for.

Walker: Operational side is vital to take into consideration; the cost to operate the building over its life outweighs construction costs 10 to 1. You are designing to operate not to build. Cheaper equipment up front might have an operational cost. Manage contractors, labor shortages. Improve operational paradigm through good design.

Group discussion: How do you create a culture of design thinking that incorporates all of that inside an organization?

Andrews: It's an educational journey; you learn through experience. Where is the organization at? Lean management? Methodology for mock-up spaces; trials involving key decision makers. For example, a suite upgrade, individuals couldn't conceptualize what it would feel and look like. It got all the way to the CD phase, and architects had a three-D model, got it in front of physicians, and we discovered we had designed it completely wrong.

Thankfully we did that model. Looking at drawings on paper, people understand how that space will be used totally differently. You have to design it right or you're just going to be redesigning it. You have to be able to feel the space. Have the conversation with caregivers: does this work?

Mewborn: Design thinking is also a culture. Focus on Lean, a just culture, and how to implement. I like the cardboard mockups really early on. People are tangible, they like to see and touch things that can be hard to see on a floor plan. We mocked up a trauma elevator, it paid for itself immediately with the very first group of clinicians; for cardiac patients, the elevator wasn't big enough to fit an ECMO machine at the foot of the bed. So early on, we got that right. Can use immersive tools, virtual reality with design thinking. Models already exist because that's how designers were designing. And there's also the impact of tech on the physical environment.

Walker: For design professionals, you need to spend more time in the field. You need to see what can be improved, construction issues, etc. A good culture of design involves continuing to learn, and the best way to do that is to see it.

How can you implement life-cycle cost analysis?

Walker: Better modeling. We need full-system modeling to understand operational costs, energy analysis, ongoing maintenance costs or repeat replacement costs. For example, you need redundancy in systems that don't have downtime.

Mewborn: Pumps, headwalls, etc. If you use often, standardize. Can update standard if something doesn't work well. This allows for bulk buying and a start on design. Talk with users, what's working well, what isn't. Maintaining standards important for life-cycle cost.

Andrews: Effective planning, strong and sound master facility plan, understand next decade growth plan for campus to future proof. Is this a larger ongoing cost issue or an individual issue? Make good decisions along the way. Value good partners, be familiar with your campus. Think bigger about projects, not just individual need but future: plan for the next tower.

What would you change if you could change anything in your business life about how to deal with project design, carte blanche?

Walker: We have so much ongoing medical data now, to improve sleep, diet and exercise, which can be processed through AI. On the patient care side, doctors ask routine questions. I'd like doctors to have conversations with

you about your habits, lifestyle and how it's impacting your health. We are drowning in data but have no information. We need situational awareness. Those platforms exist, but we need to get facility operators set up with the right data and actionable information.

Mewborn: I believe in the lean mentality – that small changes today add up over time to something bigger than one massive change that doesn't stick. Everyone should be looking at small improvements each day.

Andrews: The "hospital of the future," the future of AI, is ever changing. What our world will look like in five years, none of us can even conceptualize. How do we enable the technologies of the future? From an infrastructure \ backbone standpoint. If you have tech that would have a great impact but none of the enabling factors, that makes the tech inaccessible.

Solving the Parking Puzzle

Brent Bandy, Senior Principal, Walter P. Moore;

Dia Dopp, Regional Manager, Metropolis;

Reed Gardner, Manager-Facilities Planning and Development, Northside Hospital;

Forrest Hibbard, Parking, Planning and Design consultant, HRD

Moderator: B. Alan Whitson, RPA, founder and president, Corporate Realty, Design and Management Institute.

Fundamental Question: Why does parking suck?

Dopp: Answering that is a whole other summit. Most important is ease of use – all of the things that go into every tiny detail. There might be the most amazing tech inside the building, but it drops off outside. Coming to the hospital, you're nervous, scared, driving into the city. You're not supposed to have to think about your parking experience. Find the lot easily, push the button, pull your ticket, park quickly, get into the hospital for whatever you're there for.

Hibbard: Communication to the person ahead of time is ideal, even before they show up on your campus, hospital, multiple medical office buildings. Let them know where to park, the wayfinding strategy up front, funneling to the closest parking location. They shouldn't have to walk a long way, and they should know which building it is they're headed to. A lot of that is communication, which is easier said than done. Wayfinding and signage.

Gardner: Make it as simple as possible for your patients coming in to campus. Wayfinding is important, making clear which building they are trying to get to and the space where they need to park. Signage, and tech.

Bandy: To make the experience simple enough that the user doesn't have to think about it, we have to think about it really hard. What makes a difference? We can work on all those details during the design phase so the end user has an experience they don't remember because it's all part of the flow.

How do you plan your parking so it's not an afterthought on large campuses?

Hibbard: In planning a replacement hospital in 2011, parking was a key component. The master plan anticipated future buildings replacing today's surface lots, so we intentionally over planned parking from the start to support long-term, multiphase growth. Because hospital environments depend on easy mobility, we prioritized flat parking wherever possible. When a garage was required, we kept the first bays flat and pushed ramps to the ends to

simplify circulation. The design maximized flat parking while still accommodating future expansion.

Bandy: It's easy to build over a surface parking lot, but difficult to deal with an existing parking deck in the spot where you want a tower. A campus master plan is key. Think into the future, not just making the building flexible and functional, but making the campus functional and flexible. Georgia growing faster than ever expected -- set yourself up for that growth.

Gardner: Parking has to be the first thing considered. You can't build the infrastructure without that. There is no ROI right away, but if parking is in place and well planned, when the campus expands, you have that ready and patients aren't frustrated. Put in parking first.

What role do parking technologies play in these challenges?

Dopp: Today, a lot. We have had healthcare parking decks with equipment that still had typewriter ribbons and physical clocks you have to change. Parking tech hasn't kept pace with the tech inside the building. Tech has come a long way in parking in two to three years, almost all parking can be done with just a gate and camera, or even just with a camera.

Hibbard: Anything you're doing with parking dovetails with wayfinding. You need to go with higher clearance in parking decks. Have red light/green light systems. Follow ADA for vans, on multiple levels. It means providing an extra foot, but it pays extra dividends. Let people know ahead of time where available spaces are; don't make them search on the first level for a needle in a haystack.

Bandy: Sometimes it's a curse being an engineer – you're always thinking, "There was an easy solution for that." It's about running harder during the design phase so the user has a better experience. Good wayfinding doesn't happen by itself, but it is critical. Who is using the deck? Staff, don't need direction as much but visitors, absolutely, they are distracted and need wayfinding to be as simple and clear as possible.

Any other insights?

Dopp: Give yourself the luxury of time in figuring out wayfinding. Don't have it all up and permanent immediately; give yourself 30 to 60 days. A little time, especially in employee areas. People are like water. The crosswalk is where it should be, but they will pass through the bushes. Where does the flow go? Wherever they want it to go. Watch and see. Human decisions. This will help you to not overdesign and overspend.

Using Cleanroom Technology to Improve Critical Environments in Healthcare

Cliff Yahnke, chief science officer, SLD Technology

Our company was founded by someone who worked in clean rooms. The most important source of contamination in the OR is us. Surgical site infections are the most expensive form of infection in a hospital setting, and pathogens are hard to eliminate once they take hold. Patients have a three times higher chance of getting an infection if the previous patient in an ICU room had an infection.

Three main methods to control air flow in a healthcare setting are: four-way throw, multi-diffuser array, and single large diffuser. Only a single large diffuser eliminates air turbulence, which in turn greatly reduces contamination in the surgical field.

Visible light decontamination can provide an 80% reduction in contamination when integrated into operating rooms.

In modular construction, you can almost always get better performance than in a stick-built application. Modular construction can integrate single-large diffusers and visible light decontamination in a way that reduces costs and shortens construction schedules.

Healthcare companies need to learn from the tech world when it comes to creating contamination-free spaces.

Navigating the Annual Budget Process

Carla Bowron, Group Manager, JE Dunn;

Jason Cash, VP Planning, Design and Construction, Piedmont Healthcare;

Keeli John, Corporate Director, Planning, Design and Construction, Emory Healthcare;

Tracy Moody, System Director, Facilities Development, Northeast Georgia Health System;

James Roberts, VP, Program Management, Meadows & Ohly.

Moderator: Derek Watson, senior project director, Hammes.

How do you ensure the budget aligns with the broader strategic plan?

Cash: Make sure you hear priorities from your senior leaders

John: Early alignment, working with foundational strong processes and strong leadership, communication.

Moody: Make sure we give leaders time to make those decisions, digest conversations, and implement a spending plan.

How can you prevent the annual budget from becoming a backward-looking history lesson?

Moody: That's an important thing for us to work through; it goes back to having open lines of communication. We can't forget what our operating budgets were, the stepping stones to moving forward on items. Don't let systems get caught up in thinking money from last year is transferable to this year. Do it strategically.

John: Transition from static to dynamic capital planning; have living capital-plan worksheets you're continually updating and communicating to leadership. For projects, work closely with team, get project owners in front of our governance – the board. We are learning from our history and making better investments.

Cash: It's important to look at the past, to see what you did that was good and bad, not come up with something new every year. Looking five to ten years out, how strategically do we want to grow the system? You can't spend it all in year two and not have anything for year eight. Priorities are the same for us and for the system's leaders. There's a lot more watchfulness from

the system level now, you don't just get to go buy a golf cart because you think that's what you need for parking. There's not a free bucket of money.

Infrastructure is a constant challenge. What works with trying to justify infrastructure and deferred maintenance to leadership?

Roberts: Infrastructure is difficult for every system. But there are results of not keeping equipment maintained over the years. For us, being intentional when looking at infrastructure, what does that mean for the system? If they want to pick an MRI over a chiller, tell them, "You might have to evacuate a whole patient tower if the chiller stops." Take that information and relay it.

John: All of us are facing facilities condition assessments. Start with the data, work with finance to make sure capital is allocated and protected. This has been a change. We are challenged to even have resources to tackle that long list. Leadership understands that infrastructure is strategic and consequences are inevitable. Support with tools like heat maps, that gets the attention of the board. Consistent reporting. Tracking that information, demonstrate progress, support patient care. If we don't take care of our buildings, our teams won't have the ability to care for patients in the way they need to.

Moody: Explain how important the infrastructure is. An analogy I make to system leaders is that the hospital is the body, infrastructure is the internal organs. If that isn't functioning properly nothing else matters. As important as growth is, this can help facilitate growth.

What could owners do to assist non-tech leaders to understand?

Bowron: Get a trusted partner on board early. Ask the leaders, where are you, where do you want to be, do you want to replace what's failing? What do you need long-term? Figure out ahead of time, and then you need to get funding. Help figure out what scenarios could work.

Roberts: Capital implementation, infrastructure, and deferred maintenance. They really are important. If you do have to shut down 100 beds, that's a big deal. We had to shut down parking decks, now there is a routine maintenance plan in place.

John: It's so important to have the right partnerships and information. A facility might look good but next year, you have a bunch of systems at their end of life. It takes long-term planning and foresight to look ahead. Incredibly long lead times, down times, can't just quickly do. Requires so much planning and time. If not looking ahead, you're not leaning the right way.

When do y'all start talking to the owner about releasing some contingency money to get another project started?

Bowron: We evaluate the risks of the job, overcome those risks, then turn that money back. As a project progresses, you are aware throughout and are able to give back as you go. Don't wait until the end.

Roberts: When it's the right time to give those dollars back, manage contingency, be up front with owners: We think we'll be able to give this much back.

Cash: Contingency is something we watch very closely. We don't allow scope creep or adding things to the project. We don't say to the local facility guy, hey, you have to do this chiller, if you really don't. We have good open communication about that.

John: We are looking at contingency funds so much more closely: scope, timeline, budget. Contingency creates the budget for more projects. Not able to act on as many projects if we don't act up front.

Moody: We want you to help us be good stewards of our money. If we can mitigate risks, that's what makes a successful partnership. You are helping us spend our money intentionally and in good measure as we move forward. Just because we have the money doesn't mean we have to spend it all. We can reallocate; kick-start the next adventure.

How can you assist owners?

Roberts: Owners come to us with various projects, and we help them plan to get capital funding. We might team up with master planners, key stakeholders, and come up with a budget. We need priorities from the owners. We all work better when we have a plan. Dust off the master plan every three years: needs change, the market changes. Have a guiding light as you spend that capital.

Bowron: I think we've all suffered from lack of direction, so we're happy to help plan at any time. Understanding the goals of the job is very important. We've

also all been burned when we planned for x but you needed y. Then everyone's scrambling. You need the right amount of money for the job.

Moody: Sit down with owners, be very clear about what's in, out, and assumptions based on time to turn around.

Cash: Be honest about what the budget really costs. Get in the boat with us, or it can result in a project that doesn't get approved.

John: Recent pricing activity, working with partner, we talked about what was not impossible but unreasonable. That's your responsibility: to be realistic in what you're presenting. We want to set everyone up for success.

How can you ensure consistency across service lines, campuses?

Cash: For us, it's important to recognize that we can't fix every problem at every campus in one year. We've acquired some facilities that are not what we would want our campus to look like. Let's spread our money as far as we can.

John: I try to anchor back to standard policy, processes, and templates, which is a challenge with 11 hospitals and more than 200 clinics that have acted independently for a long time. It's a multiyear process. There is a balance in creating consistency and partnerships, not being seen as bureaucratic.

Moody: We are not able to see as many facilities as we'd like in person, but someone else may see regulatory issues. Please communicate that back to us, it will help us prioritize for our leadership team. Regulatory items first, take priority over other items. Allow us to use you as our eyes out in the field.

What might you suggest to improve the process over time?

Bowron: Our challenge is resources. Planning the next project, picking the right team. A peek behind the curtain to see what's coming: help plan, organize, and prepare.

Cash: With 27 hospitals, if the CEO calls and asks you, "How much is it going to cost to do this?" don't just give him a figure, bring it to us for approval. Contact someone on our team and give us a heads up, or it can delay the whole process. We have to validate it.

John: I would echo that: Slow down to go fast. If we don't put in the time upfront, it's just going to have to start over again. Be agile. Turning down some of

the loud voices that tend to deviate from the process is always a challenge for us.

Moody: Communicate with us, try to centralize the information. Be intentional in your responses. Let's prepare a better snapshot. If I don't know critical answers, I will get back with you. There may be some things we know that you don't know.

Roberts: Go back to the master plan. Make sure leadership and frontline staff understand what it looks like. If they want to deviate after that, fine, but understand it's a deviation.

Making Hospital Rooms Smart

Lorry Lewis, VP Operations, DeKalb Operating Unit, Emory Healthcare;

Brian Murphey, Associate Principal/Technology, Introba;

Michelle Tillis, Chief Nursing Informatics Officer, VP Inpatient Services and Treatment, Children's Healthcare of Atlanta.

Moderator: Dr. Garold "Gary" Hamilton, Senior VP, North America Growth Leader, Introba.

What drives a smart room's design smart? Are there generational differences?

Tillis: Yes, we had a unique opportunity to build our smart hospital from the ground up. The main drivers were: Its vast size, so we wanted to design it to reduce steps and save time. We wanted to help people stay connected and have information at their fingertips. And we wanted to improve everyone's ability to make decisions for care. Finally, if we've done well, the technology fades into the background. We want it to be an enhancement to patient care, not a barrier. As far as generational differences, we're a pediatric facility, but we do have everyone from babies in the NICU, where the focus is on families, to teens, who want to be able to connect with friends

Lewis: We had the chance to ask, what if we use Apple tech, which hasn't been done in healthcare before at this scope. We switched things over to Apple: batteries last longer; bigger and more clear screens, computer on wheels lasts 20 hours. Patient rooms all had iPads in the room and iPads at the doors. We didn't see much difference in generations, we had 80- to 90-year-olds using tech, iPhones. There were some issues with accessibility for, say, stroke patients, etc. Our younger staff uses mostly iPhones; the older staff love the carts.

Murphey: Our job is to implement; we don't make the decisions. Doctors and nurses are there to help patients and be care providers. Patients are there to get better and go home. Smart rooms should disappear into the background and make jobs and stays easier. The technology should be seamless and help everyone focus on their purpose for being there.

Traditionally, hospitals have systems that operate on their own networks. Smart patient rooms require integration. How do you as a designer ensure that this is done?

Murphey: Third part of technology, when integrate, you get additional capability that sits above all the individual capabilities. Key to making sure you have the ability to integrate is to make it a design priority from day 1. If you decide

you're going to build a new facility or renovate an old one, think about interoperability right then. Not after you put in all the systems. Don't just think: "IT people will figure out how to make them all talk together." Who is going to own individual systems? People in the hospital have to define that. Where is the source of truth for the data going to be, if it's stored lots of different places. How is that data going to be shared between systems? Defining that up front is very important. How are you going to secure this data? Especially true with AI. Massive amounts of data shared with training models, some very sensitive, create lines in the sand before talking to vendors.

How do you evaluate the business case for this?

Tillis: Always start with which problems you're trying to solve. Get really clear about that. Demonstrate the value and impact of employing top-line technology. Tech really was an added quality for our feedback scores, as both a tipping point and brand differentiator. Having smart rooms and up-to-date technology is an expectation of our clinicians. They won't come work for you if you don't.

Lewis: How can we put our clinicians back by the bedside? ER physicians say 60 percent of their time is spent in front of a computer. Get them time to do what they want to do, which is patient care, so they won't want to leave. Employee engagement scores skyrocketed. Staff leaving went way down. Give them time back to take care of patients. Patients felt included in their care, it wasn't just something being done to them. They could see labs results and know what to ask physicians.

What is the best time to bring in a consultant?

Murphey: Bring somebody in to help you start developing a strategy and plan at the very beginning. Construction is linear, planning is not; it happens in waves across a broad area. When planning for a patient room, you're not really deciding on tech early on but on what problems you're going to solve. It can't help you with cultural things. You have to understand where it can help. These are long, messy, difficult discussions. Having someone come in to facilitate is helpful.

What are we doing to make sure that we are ready for the next technology leap?

Tillis: We are intentional to be as agnostic as possible, and have agile and flexible platforms not tied to specific vendors. What does future look like on

precipice of AI? Ensuring core infrastructure, with the ability to adapt and pivot.

Lewis: We don't know what we don't know. If you have a hospital that's 20 years old, you'll be adding a lot. Add more closets. Have more electricity coming in.

Murphey: And lots of cable. Lots and lots of cable. Lots of cooling, power. Think big on infrastructure. Yeah, it's expensive, extra cables in ceiling, but it's not wasted money. Within a year, it will all be used for something.

Why is there such a slow adoption of smart patient rooms? Capital? Regulations?

Tillis: They are complex. The stakes are high, with good reason. At the end of the day, patients' lives are on the line. It's the right thing to do, to make the investment, but it just takes time and real dollars.

Lewis: Our staff now come to me with requests because they're invested in the technology. As we're adding AI and other capacities, we are really going to have to be able to demonstrate value. For example, if by using AI you can help predict when a patient is getting a pressure injury, that is real impact.

What is working and what is not? What are some things you would do differently?

Tillis: Minimize the amount of change staff experiences on day 1. We made all the changes and came back in, looked at the data, and were a little surprised that our teams weren't using the tech. Part of it was that there was friction in the experience. We spent the next couple of months finding out how our clinical teams interact with tech, and the barriers and value. We did a lot of redesigns, and learned enough about work flows to make the use of the tech intuitive. Also, the reliability of the tech is important. Today, tech adoption is improving. We have to prove to CEO it was worth the investment.

Tech integration is not static; it's a living system. How can you make the ongoing process better, for the long run?

Lewis: Find your partners. Learn from them, what they did or wouldn't do again. They've already done it. As we accelerate as an industry, we need to stand on each other's shoulders.

Murphey: Be able to have systems piloted, mocked up, used by a broad cross-section of end users while you still have time to make changes. Don't let the first time that teams see it be a week or two before patients arrive.

Involve a broad cross-section of staff, not just tech savvy super users; pick people at random.

Have you seen an improvement in length of stay?

Lewis: Yes, we've seen a decline in length of stay, some from virtual nursing because they can do the discharge. And the staff is able to provide the patient with a lot more education, right at bedside.

Integrating Behavioral Health Care and Medical Facilities

Kimberly McMurray, Principal, Behavioral Health Facility Consultants;

Chris Ressler, Regional Healthcare Director, Associate Principal, Page/Stantec;

George Smith, Senior Architectural Project manager, Grady Health System.

Moderator: Erin Carlson, Vice President, BDR Partners

Can you define the problem?

McMurray: There is one suicide every 11 minutes. It affects the whole family unit. It's OK not to be OK. Most saw a provider within months of their event. Suicide rates were climbing steadily, then they went down. Males are four times more likely to die by suicide than females; 85 and older is the most at-risk age group. Some have been diagnosed with a terminal disease and don't want their family members to be burdened. There are many stories, many journeys.

Ressler: We have to start normalizing the needs of behavioral health patients. One in five Georgia teens have considered it. America is being forced to acknowledge and respond, and to change the way we view, design, and treat mental illness. The stigma around behavioral health treatment has eroded. For most of us, it's gone. Most of us know someone who has mental illness. More often now, mental illness is viewed the same as heart attacks, it's part of the dialogue now, part of pop culture. In *Ted Lasso*, the invincible main character, built on optimism and hope, suffers panic attacks. And who expected in the last *Shreck* movie that Puss and Boots would have crippling anxiety? True conversations lead to true solutions. Also, evidence-based design is back in behavioral healthcare facilities, design has started coming back to data and patient outcomes, but only as recently as the 1980s. Daylight and natural light, windows. Autonomy and control. Tech and security are so much better, so much smarter. Current facilities can keep patients and staff safe without them feeling trapped.

EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) units are ways of treating behavioral health patients better in the ER. How do you view them?

Ressler: They take into account trauma-informed design: treat with dignity, acknowledge trauma, create spaces that deescalate and don't make patients fearful. The game has changed, not because of more money, but

because patients weren't being healed, they were just being held. We need holistic spaces of healing, not retention.

Smith: We are the safety-net hospital for downtown, and we have changed the way we handle observation to an almost-EmPATH model. It allows us to see patients individually and not cohorted with chairs all together. Open spaces, with staff in the space working directly with patients in one- on-one, less confrontational manner. We've reduced restraints, reduced drugs. It's not for everyone. Some patients still need restraints. But the staff is trained to de-escalate. An EmPATH unit is an entry point to a continuum of care. There aren't a lot a lot of frequent fliers. It provides answers and a path forward.

McMurray: Recognize that the mental health journey is not a linear process, it's up and down and back and forth. So, the treatment philosophy will need to be considered for the rest of their lives. Behavioral health facilities still must follow codes and regulations. Ligature attachment points can be invisible. If patients want to hurt themselves, they will find a way.

Backfilling Hospital Space: Opportunities and Challenges

Thomas Doenitz, VP Design and Construction, Grady Health;

Emily Marvel, Principal, May Architecture;

Magnus Nilsson, Director of Construction Management, Emory Healthcare;

Robin Saxon, VP, Real Estate, Construction and Facilities, Wellstar Health System;

Rafi Wartan, Principal/Regional Director, TLC Engineering.

Moderator: Gil May, Founding Principal, May Architecture

Hospitals are always out of space. What are the things that cause you all to have space to backfill?

- I would say, for us, it's when we have a need and we have to move somebody out. We had to move people into the cafeteria to wait because there was no room in the surgery waiting area. So, it's almost always need that drives us to identify who can be moved out of the hospital.
- We're seeing a lot of the same thing, a lot of office spaces that could be utilized in a much better capacity. We've got several projects where we're moving offices out of the hospital and turning that into patient care areas.
- When you're talking about the inpatient chassis, it's getting rid of the non-revenue producing or the lower acuity services that could be done outside a hospital setting or working from home.
- Opportunities exist in most hospitals to make better use of that inpatient space. If you're in a 75-year-old hospital, you have probably packed a bunch of things away in there over the years. Going through the hospital to ensure you're making the best use of that very expensive real estate is an exercise I think everyone goes through.

When you do push somebody out and space is created, can you talk a little bit about how you determine the best and highest use for those spaces and what those conversations look like?

- Your facility master planning should closely follow your strategic plan. Then your financial planning and your pro forma should be a part of determining what needs to grow and what is going to be revenue producing for the bottom line. Those things need to happen in very close concert with each other. Most of our renovations are around strategic initiatives to grow certain service lines and to refresh space that hasn't been touched in years.
- This strategy drives, and then we find the space. It usually comes in from a much higher level and then it gets pushed down to us to implement.
- It's usually the hospital leadership driving these decisions, but they aren't walking the halls. They don't really know what's happening. So, you end up guarding spaces like, not cutting a waiting room in half. How do we create a system where there's kind of a

clearinghouse, a committee, that if you want to change the four walls of the hospital it has to align with our strategic master plan? That's what we're going through right now.

Do you all have committees within your organizations that review these decisions, and if so, how does it work? Are you ever in a situation where somebody wants to do something and y'all have to tell them it doesn't work?

- It happens all the time, where a project gets pushed down and we have to go back and validate, is this the right thing to do? Do we have the space to comply with current codes? Is this the best use of that space for this patient need? It's a constant evolution.
- Strategic projects are driven by the master facility plan and route through the building committee. Then there's the smaller, run-of-the-mill renovations: “I need one more of this room,” or “I need to grow this particular service,” or “I need some storage.” We have a project intake committee and an online portal where our clinical users can enter their requests, which are reviewed at a VP level and then circulate to a multi-disciplinary committee that meets every two weeks. Requests are evaluated for feasibility and the capital they will require. The committee’s decision drives whether we engage architectural and construction resources.
- We have an intake form to understand where the project is coming from. What's driving it, is there a funding source? If not, how can we help with that? Once a project or a concept has been identified, we seek help from our AEC community to develop and test fit a discovery package and determine a total project budget.

From an engineering and an architect’s perspective, what are the issues you see clients run into that they haven't considered, that they should be thinking about during the validation process?

- When the owners are developing a budget, that’s when they might call an engineer and we come in and create all the havoc (laughter). You know, we're looking at things like, is the [infrastructure] up to date? Can it handle what you're trying to put it into? Has equipment been maintained? How old is it? If you have a plumbing project, what’s under it? What else is going to have to shut down for you to implement things? This can impact the budget.
- I like to bring in construction partners, especially for some of our tighter sites that have massive constraints, to help us understand the logistics required to bring materials and people into the area.
- Healthcare has a knack for being able to do so much more with what they have than what they ought to be able to do. Sometimes the mistake is assuming you can build more of what you already have. But there may be a new code regulation or an FGI clearance regulation. I know you have rooms that size today, and you are making them work, but you wouldn't be allowed to build it again that way.

- And then there are things like the data closet; are you planning for the future? Is there a chance you might want robotics in there at some point? Go ahead and make it a little bit bigger.

Could you talk about some of the strategies you use to build consensus with all the different stakeholders?

- You look at pros and cons, and staffing. Is this the right number of beds? What is their acuity? What are the nursing numbers? Do we have available staff?
- Make sure you have the right players in the room early and make them part of the process. I don't think any clinical group or support group within the hospital hates anything more than being handed the keys to a space and hearing, “OK, this is yours, now go operate it,” without having been there from day one. Even if it's a beautiful space, if they weren't part of that creative process, they're not going to own it nearly as much as if they sat across the table from the architect, describing what their pain points were in their current space and what they want to improve in the new space.
- Make the time to bring all the key stakeholder groups to the table early and often. We bring them back at every phase. It's one thing to sit with your primary user, it's another to bring in EDS, IT security, food services. You'd be surprised how much frontline information you gather from support staff, because they're patient facing too. Information you’d never gather on your own just walking around. You can't capture all the information that those people have in their brains from working in that space every single day.
- Nothing slows the project down faster than if a decision-maker is not a part of the process early, but becomes part of the process later, and then there's rework, schedule delays, etc.

Let’s talk about some of the challenges when you're designing and building out backfill space in an operational hospital. What do you do to minimize the impact on the patients and the workflow?

- A hospital, like any healthcare facility or even outpatient facility, is this iceberg of moving pieces. We've got to work as a team with the owner and the contractors to figure out a phasing plan that works. It’s not as simple as just breaking it into smaller, bite-sized pieces. What is available during each phase, and how does it function? What spaces that are available? What does that mean for compliance? Do they have all the pieces and parts required to operate? For the contractor and construction team: How do they get themselves and their materials into the space to be able to work? What does that equipment plan look like? How do you keep that traffic separate from the patients and visitors? It's complex and definitely a team effort.

Can you talk from the owner's perspective about disruption of operations?

- We're in design on a project right now and are starting to talk about the phasing because it's so important. We're going to be inside the patient space; adjacent, above, and below. We have to be extremely cautious about the type of work we're going to be doing. Is it loud? Is it disruptive? What times of day are we going to be working? Our pre-construction risk assessment form is 15 pages long because of all the things you have to think about working at an urban campus that is 70-some-years old. Having your contract partner at the table as early as possible is important. How do we implement this work and keep operations going? And even then, you're going to have surprises, and you need to have mitigation plans in place.
- Getting the right operational partners at the table early, that's most important. If you haven't notified them that the electricity is going to be out, or they're not going to be able to use this room, or the water's going to be out in this faucet, those are big issues. We spend a lot of time planning with paper, too.

Could you talk about some of the pitfalls you've seen during construction with all those phases, from an engineering perspective?

- Yeah, it's usually the systems that get you: the fire alarm system, the nurse call system, the technology system, that get interrupted. You've got to do that planning ahead of time, understand the limitations of the systems, and put them in the budget to get corrected or upgraded as necessary. Those are the surprises. Do your due diligence before the construction.

Last question, can you all speak about the communication that you go through when you're doing a project, when you start communicating to the staff?

- Besides just at the project management meetings, we would make sure these operational changes are talked about at the daily leadership huddle, well in advance of anything happening, so that it's a constant reminder: December 6, this is going to happen.
- We do a weekly look ahead about what is happening, what we're going to do, what the construction is going to look like from that day to the next week. There's always communicating to key leaders about who's going to be impacted, and what kind of noise they could be experiencing.
- I'm a huge advocate of having a multi-disciplinary meeting, so the immediately affected parties are acutely aware of what's coming. We have a robust utility disruption and shutdown process. We start that process weeks in advance if we're doing some major power, steam, water, or air shut down. The list of signatures on that form is probably 15 or 16 people, just so we make sure all parts of the organization are aware at a leadership level.

- If something is widespread and going to impact the entire hospital, we publish that in our internal newsletter so that every employee is aware there's a major shutdown or disruption coming. Multi-channel communication, early and often. Our staff members, to their credit while having that much activity going on, are really good spirited about it and roll on pretty well.
- If you're doing a major shutdown, having the trade partners on site for the surprises is a big deal. If there’s an electrical shutdown, make sure enough electricians are around that if something unexpected happens, there's a response team that can take care of things.

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