Executive Summary
11th Greater New York

Hospital, Outpatient Facilities & Medical Office Buildings Summit™

April 16, 2026

What's Next for Healthcare Facilities

Addressing Vital Economic, Design, Construction, Workforce, and Operational Challenges

Planning, Real Estate, Design, Construction, and Operation of
Hospitals | Clinics | ASCs | MOBs | Tele, Home & Mobile Health
Non-Clinical | Academic & Research

This Education and Networking Event is Presented by
Corporate Realty, Design & Management Institute
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Executive Summary:

- The Evolution of Operating Room Design – Why Early Decisions Matter
- Crossing the Chasm: From Substantial Completion to First Patient
- Strategic Intelligence: Building Smart Hospitals
- Backfilling Hospital Space: Opportunities, Challenges & Solutions
- Project Delivery 2.0: The New Toolbox
- Integrating Behavioral Health Care & Medical Facilities
- Hearing the Clinical Voice: Integrating Nurses and Frontline Providers in Facilities Planning
- Healthcare at the Crossroads: Capital Pressures & Facility Investments

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This executive summary was written by Michael Odenthal (modenthal@gmail.com) a freelance writer based in New York

The Evolution of Operating Room Design: Why Early Decisions Matter

Jeffrey Berman, Principle, Jeffrey Berman Architects
Anna DiLorenzo, Clinical Advisor, OR Safety & Performance, SLD Technology
Jason Lukes, Associate Principal, BR+A
Dan Paesano, Vice President, Healthcare Lead, JLL
Cliff Yahnke, PhD, Chief Science Officer, SLD Technology

Panelists discussed the history of operating room design, necessary advancements in harm reduction, varieties in pre-fab options, conventional multi-vendor systems vs. fully integrated single-vendor systems, and the monetary implications of healthcare-acquired infections.

- History of the operating room
    - Science has made radical advancements from the early days of non-sterile, backroom surgeries.
    - Currently living in a time of great innovation, including advanced imaging integration and robotic surgeries.
- Three major types of pre-fab OR integration (in order of increasing value)
    - Kit-of-Parts (or Stick-Built)
    - Field-Installed Modules
    - Fully Integrated, Factory Assembled
- Value in going modular early
    - Clients increasingly expect speed and reduced cost in ORs and radiology suites
    - Involving more complexity into ceiling structure – more trades, more people, more equipment – will add to those costs. Packaging solutions early can reduce expenditures while preserving quality.
- Renovations vs. new builds
    - Many similar problems, i.e. introducing complex infrastructure into small rooms
    - Pre-fab has a risk of locking in a function for a room; companies that can build flexibility into modular packages will find success.
    - New construction is all tradespeople on-site; renovations require acknowledging an active, multi-purpose work site.
    - Modular rooms can provide easier access to ceilings should issues arise.
- Modular maintenance
    - Everything accessible and replaceable from room-side.
    - Documentation is clearer as it stems from a single source, rather than myriad tradespeople.

“Modular construction leads to better air-flow performance, and thus less pushing of contamination. Owners should be encouraged to advocate for modular as they turn rooms over faster and create better performing systems” - Anna DiLorenzo

Crossing the Chasm: From Substantial Completion to First Patient

Jerome Bermudez, Senior Project Manager, New York Presbyterian
Madeline Julian, Assistant Vice President, Capital Project Management, Columbia University Irving Medical Center
Jacobie Ricard, Assistant Vice President, RWJBarnabas Health, Robert Wood Johnson University Hospital
Bin Weng, AIA, NCARB, LEED AP, EDAC, Senior Principal, CPL
Neil Wright, Vice President, Activation, Meadows & Ohly
Moderator: Mitch Green, Senior Vice President, Tishman Construction

Panelists discussed the process from construction completion to a facility performing as a viable healthcare unit, using a hypothetical NYC ambulatory care project that relocated existing services as an entry point.

- Lessons learned
    - Every phase of a project is the most intense phase for one member of the team, thus essential for every stakeholder to understand the completion vs. patient-ready timeline.
    - Activation team should be brought in early to consider downstream ramifications for decisions affecting every stakeholder, e.g. how a seasoned nurse will eventually navigate a planned space.
    - Communicate the increased complexity and verticality of healthcare systems in a way that considers those stakeholders who *aren't* in the room to maximize effectiveness.
- Common failures
    - Overestimating team capacity. Failing to rope in operational planners throughout a project who can identify potential problems in advance.
    - Regulators may identify compliance issues post-substantial completion. It requires experience, knowledge, and consistency to resolve late-game issues.
    - Projects are long, and tech will evolve throughout their duration. Should not be a surprise when re-calibration arises later in the initiative.
- Timing
    - Activation should always have begun yesterday. These projects are exercises in observing human behavior, imaging how each stakeholder might need to operate in a new space.
    - Transition planning should start at least 12 months before going live.
    - Activation champion should be someone with a deep knowledge of the project and can make people listen with authority and accountability.
- Costs
    - Activation funding allocation depends on project size and complexity, but 3% is fairly standard for a larger effort.
    - There are no dream projects without activation issues, but the less siloed individual stakeholders are, the fewer the problems.

"Activation is like composing a refined piece of music; it requires an A+ communicator who can effectively navigate between worlds even if not necessarily an expert in all of them" – Madeline Julian

Strategic Intelligence: Building Smart Hospitals

Brad Bonfiglio, National Director, Consultant Solution Architects, Schneider Electric
Nicholas Burgess, Division Lead, Building Intelligence, JB&B
Jonathan Liang, Director of Plant Operations, Memorial Sloan Kettering Cancer Center
Moderator: Westmore Bowman, Strategic Account Executive, Healthcare, Schneider Electric

Panelists discussed the evolution of smart hospitals since the introduction of the term in the 1970s, recent tech innovations, goal-oriented implementation, energy saving strategies, prioritizing practicality, and the future.

- What is a smart hospital?
    - Term originated in the 70s related to costs and efficiencies, but obviously usage has since evolved.
    - Now can refer to a care center that uses anything from patient-facing apps to a small suite of sensors
- Smart implication
    - Incorporating the latest tech for its own sake can lead to data overload and inefficiency. Important to game out who might use any new technology and discuss those potential use-cases with them.
    - Improving patient care should always be at the center of the conversation.
- Emerging technologies
    - Fault detection and diagnostic systems can maintain building compliance and eliminate waste. They can also help schedule various tasks based on usage data.
    - Are the appropriate people looking at the diagnostic systems? Is info tailored to specific potential users? It can help to share info across different teams.
    - Properly scheduling maintenance and services is not just useful but essential, as energy savings lead to best ROI.
- Prioritizing technologies
    - Ask what staff is lacking, and where there is waste. Will a systems upgrade yield energy savings?
    - Essential to walk a site, speak to staff, and properly identify pain points. What are group leaders identifying as their ten-year plans?
    - Offer practical solutions to real and stated issues.
    - Adding tech that doesn't fix a problem to potentially *anticipate* a problem is ineffective.
- The future
    - Heading toward autonomous operating facilities. Advanced training can turn staff into "super techs," rather than rendering them obsolete.
    - Single-sourcing of info. Streamlining workflows and processes.
    - Predictive maintenance systems that know when to assign work orders and to whom.
    - SaaS model will be the future of industry; everything will exist on the cloud rather than internal servers.

"If there's something we *can* do but hadn't even considered yet, that could be a red flag, and a risk on a billion dollar project. It's important to test tech integrations on a smaller scale whenever possible before incorporating them system-wide" - Brad Bonfiglio

Backfilling Hospital Space: Opportunities, Challenges & Solutions

Daniel Ahn, Vice President, Planning & Design, Catholic Health
Christoher Botsch, RA, AIA, Director of Design/Central Region, Northwell Health
Antonio Cabrera, Vice President, Director of Healthcare, Hunter Roberts Construction Group
Ciro Fraschilla, AIA, Principal, Mascioni & Behrmann Architecture
Samantha Herbert, Senior Project Manager, Planning Design + Construction, Memorial Sloan Kettering Cancer Center
Moderator: Jonathan Hernandez, Partner, Gilsanz Murray Steficek

Panelists discussed the definition of backfilling from a hospital facility perspective, expectation vs. reality in these types of projects, common constraints, and regulatory issues.

- Defining backfilling
    - While often considered in purely construction terms, it really refers to a successive, lower-profile job that follows a larger undertaking.
    - Can involve a whole new project in an existing space, or the creation of swing space.
    - Finding a way to do something essential in a less-than-ideal location
- Expectation vs. reality
    - Often times expectations involve small tweaks and/or simple modifications, but aged buildings w/lackluster infrastructure can create complications.
    - Can be difficult to explain scope of work to leadership and receive necessary approvals.
    - Should be considered during masterplan process and not just as an afterthought.
- Constraints
    - Have to ensure space is usable and up to compliance. Requires input from both consultants and professionals who will have to work within the space.
    - When infrastructure is lackluster, much labor may be needed to allow proper air circulation and ventilation.
    - Essential to educate stakeholders on magnitude of work early to appropriately set expectations.
    - Non-clinical spaces are often expected to easily convert to clinical use, but that can often have structural implications.
- Regulatory issues
    - Converting non-medical space to medical space requires more approvals and a longer lead time before construction. Stakeholders must anticipate all potential uses for a space as early as possible.
    - Important to understand during planning phase what type of work might trigger regulatory scrutiny, in order to anticipate scope of review.
- Disruption of standard operations
    - No easy fix – any project will impact sensitive times specific to adjacent spaces.
    - Minimizing disruption requires a custom room-by-room strategy.
    - Stakeholders may encourage you to “go, go, go,” especially for a late-game piece of a major project. Logistical planning and effective communications can keep the focus on patient care.

“Are stakeholders looking at a backfill as a stand-alone project with its own approvals, or is it a late-phase piece of a long-conceptualized effort? Understanding clients’ governance is essential, as you’ll own the repercussions down the line” - Daniel Ahn

Project Delivery 2.0: The New Toolbox

Austin Delaney, Executive Vice President, Technology Consulting, HBS
Melissa Kiefer, former Vice President, Facilities Development & Regulatory Affairs, Hospital for Special Surgery
Denis Leff, Director, Digital Engineering, Suffolk Construction
Emil Martone, AIA, Director, Design & Construction, Weill Cornell Medicine
Moderator: Jonathan Cogswell, VP, Manhattan Development, Design & Construction, Northwell Health Services

Panelists discussed the combination of higher stakes/expectations/costs, incorporating AI and other new tech, utilizing that tech to better scrutinize historical data for optimization, and staffing considerations in the current technological landscape.

- Room to improve
    - Avoiding new projects when possible by better using existing space.
    - Fees cannot be lowered further to better compete for jobs; tech must be productively eliminated to streamlining project plans.
- Shiny new tech
    - Not one tool that's broadly adaptable for a wide range of projects/specialties. Even GPTs have serious variance. Important to start small and with intention to develop one's familiarity.
    - Acknowledge that we'll stumble with new technologies. Have grace with one another and be willing to experiment
    - Ambient speakers, various types of machine learning, AI can all help scrutinize minute data that even the seasoned professional cannot pay close enough attention to.
- Cost-saving strategies
    - Defining pragmatic goals early can help establish cost estimates and envision risk, and you can incorporate tech to envision eventualities from there.
    - AI can identify recurring issues/costs, bring those to design teams early.
    - Machine learning could more holistically envision a project, impact on various stakeholders, and expenses in a directional capacity.
    - Integrating tech like patient support portals is a major expense. It's always a lift to launch something new and hard to explain in an ROI capacity that will free the necessary resources.
    - Convince money-holders to be visionary through honesty. Taking a successful risk at this point could be game-changing. If nine out of ten experiments fail, that one successful test could still end up paying for all the rest.
- Further implications
    - Passive video - we should be able to watch job sites not only to assess risk, but to assess workflows and ensure that everything is functional and efficient.
    - Can't really bill for use of automation.
    - Management tech often incorporated into upfront costs.

"When we bring material to job sites too early, it can cause complications. We want to be there as soon as we need it. Tech should be able to help optimize balance between necessity and delivery times" - Denis Leff

Integrating Behavioral Health Care & Medical Facilities

Thomas Drumm, Project Executive, Consigli Construction
Edward Goytia, AIA, LEAN SSBB, Associate Principal, NK Architects
Shane McCaslin, Project Consultant, Kingsway Group
Rafael Mejia, Architectural Designer, Northwell Health
Gabriel Ruben, Project Manager, New York Presbyterian
Moderator: Erin Sharp-Newton, M. Arch, Director, Centre for Urban Design and Mental Health

Panelists discussed integrating mental healthcare into medical facilities in ways that optimize patient care, assuaging the concerns staff and patients may have about incorporating behavioral care into medical spaces, and restorative best practices.

- Dealing with stigma
    - Medical practitioners don't always want to share space with mental health specialists and patients at risk of episodes.
    - Use existing barriers to keep everyone safe while avoiding appearance of "transitioning into mental health section."
    - Make the space feel more like a hotel, less like jail.
- Restorative design
    - Create healing spaces that are curative to not just patients, but staff.
    - No healing without safety and security.
    - Assess the needs and skillsets of everyone utilizing the space to create nourishing environments that take into account more than meeting budgets and codes.
- Construction challenges
    - Older behavioral units tend to be focused on containment and control, with patient experience a much lower priority. But safety and healing can supplement one another if ownership, design, and construction are aligned.
    - We've come a long way from cold, stainless steel. Now much more warm, naturally lit, soothing materials.
    - Products must be functional and work together while still projecting a therapeutic and soothing atmosphere.
    - Daylighting and outdoor spaces are also a boon.

"Pre-emptive mock-ups can eliminate later problems, as products tend not to combine as seamlessly in behavioral care spaces as they do on the medical side" - Thomas Drumm

Hearing the Clinical Voice: Integrating Nurses and Frontline Providers in Facilities Planning

LarriJo Boone, RN, Design Researcher & Clinical Nurse Expert, EwingCole
Carleen Graham, PhD, MSN, RN, Associate Professor, Mental Health Nursing Course Coordinator, Felician University
Lydia Guo, AIA, Senior Project Manager, Design & Construction, Montefiore Medical Center
Sherri Jones DNP, RN, Director, Facilities Strategic Planning, New York-Presbyterian Hospital
Tom Morgan, Director, National Healthcare & GPO Programs, Assa Abloy
Moderator: Justin Lundy, Senior Project Manager, LF Driscoll

Panelists discussed successful identification of end-users, incorporating nurses into project decisions without distracting from their other labor, involving nurses in design discussions, and knowing how to ask the right questions of stakeholders

- Identifying the end-user
    - As project planning processes get more granular, it becomes even more important to talk to the people actually caring for the patients.
    - Bring nurses in early during design phasing to assess whether project managers are even addressing the current problems.
- Consulting nurses
    - Discuss centralized vs. decentralized nurse stations. Former limits patient visibility and can create safety issues. Allowing nurses to address best use of space can optimize design and minimize risk.
    - Cannot loop every stakeholder into every conversation, so program optimization is necessary. Maintain a clear and strategic chain of communication.
    - Access control must protect critical areas, staff, patients, and visitors.
- Discussing design
    - Nurses don't need to be experts at reviewing schematics to offer essential insight. All stakeholder perspectives are worthy of consideration.
    - Mock-ups can bring basic 2-D drawings to life; can increase fidelity of design options as you go. End-users can best weigh in on functionality when they can visualize the space.
    - Design team should walk the floor with nurses to better understand purpose, pain-points, and workflow optimization.
    - Not always essential to provide endless options so much as asking end-users the right questions about workflow and patient safety.

"We need patient advocates in pre-design, concept design, schematic design, etc. to assess whether each step continues to address the initial intent and aspiration of the project. You need to make time to educate stakeholders as to the implications designs may have on their work" - LarriJo Boone

Healthcare at the Crossroads: Capital Pressures & Facility Investments

Austin Horan, Associate Vice President, Finance, Montefiore Health System
Tina Macica, Associate Vice President of Design and Construction, Montefiore Health System
Clayton Mitchell, PE, CEM, Senior Vice President, Corporate Facilities and Real Estate, Yale New Haven Health
Luigi Tirro, MS, CHC, Senior Director, Facilities Development & Capital Projects, Northwell Health Southern Region
Moderator: Rahul Tikekar, PE, MS, MBA, Principal, Senior Vice President, Loring Consultant Engineers

Panelists discussed construction cost constraints, capital strategies, balancing revenue with clinically critical care, energy costs in the age of AI, and selling a project to the C-Suite.

- Capital pressures
    - Wars, pandemics, recessions… always going to be *something* happening to impact financial resources.
    - Healthcare has fixated on customization while other industries cut costs embracing standardization.
    - Current contrast between fluctuating regulatory state and aging infrastructure.
    - Will need less administrative office space going forward. Important to find areas like this on which the industry can align.
- Balancing act
    - Prioritizing growth at all cost can miss strategic opportunities as clinical operations and equipment evolve.
    - More access to current info leads to more opportunity, as capital isn't there for a "build it and they will come" approach.
    - Age of AI is upon us, but electrical capacity and infrastructure necessary to facilitate adequate IT rooms is still an undertaking.
    - Lot of data out there, but the challenge is to convert it to a usable format that's communicable to leadership.
    - If you know broadly where you want to be in two years, you can utilize data to strike when programs are available and affordable to sustain a project.
    - Optimizing facilities management and energy efficiency can create opex; owners need to make quicker better decisions from top-down rather than delegating responsibilities.
- Selling the C-Suite
    - Prioritize end-user first. Don't make it a C-Suite problem until you understand a project inside out, at which point the case should make itself.
    - Bring in all knowledgeable stakeholders early to get broadest view of the essential data set.
    - Hesitate to incorporate shiny new tech without a long-view of its viability. Don't assume owners will pay to develop unproven technology. Onus is on manufacturers to present use-cases.
    - Focus 90% of core business on proven methods we already understand, so that 10% can be allocated on fliers.

"We're paying more and being reimbursed less for every service we deliver, so our only option is to become more efficient and effective" - Austin Horan