Executive Summary
5th Greater Central Florida Region
Tampa Bay - Greater Orlando - Space Coast

Hospital, Outpatient Facilities & Medical Office Buildings Summit™

February 19, 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
Association of Medical Facility Professionals
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Executive Summary:

- Looking Ahead: Healthcare Industry Outlook 2026 and Beyond
- Healthcare at the Crossroads: Capital Pressures & Facility Investments
- Tips, Tricks of the Trade & Traps to Avoid
- Power Under Pressure: Keeping Healthcare Running When It Counts
- The Evolution of Operating Room Design – Why Early Decisions Matter
- Extending & Protecting the Life of Capital Assets: Strategies for Economic and Weather Volatility
- Security in an Era of Increased Violence
- How Great Design Improves the Bottomline!

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Looking Ahead: Healthcare Industry Outlook 2026 and Beyond

Laura Gurley, Healthcare Strategy Associate, DPR Construction

Robert Meyer, Healthcare Strategist, DPR Construction

Laura Gurley and Robert Meyer of DPR Construction opened the summit with a data-rich examination of the financial, demographic, and technological forces reshaping the healthcare industry in 2026 and beyond. Drawing on research from the Advisory Board, Trilliant Health, and other sources, they presented five major themes confronting health systems nationwide — with pointed implications for Florida.

Theme 1: The Healthcare Math Isn't Working

Health systems are being squeezed from multiple directions at once. Operating margins improved from their 2022 low, but roughly 40% of health systems were still operating in the red as of mid-2025. Median year-over-year margin growth was 14%, masking wide performance gaps between systems. Revenue has grown, but margins have shrunk — driven by labor costs, particularly in the South.

Theme 2: Constraint-Driven Growth

The One Big Beautiful Bill Act (OBBBA), signed into law in 2025, sets in motion sweeping Medicaid and ACA cuts that will hit health systems hardest in 2026 and beyond. Key provisions include:

- An estimated 14.2 million Americans projected to lose insurance coverage by 2034, the largest reduction in U.S. insurance enrollment in history.
- An $84 billion projected increase in hospital uncompensated care by 2034.
- New Medicaid work requirements (80 hours per month) taking effect Dec. 31, 2026, with redeterminations required every six months starting Jan. 1, 2027.
- Caps on state-directed provider payments and reductions in the 340B drug discount program.
- Florida-specific impact: Up to 990,000 Floridians projected to lose coverage over 10 years; two of the state's 27 rural hospitals face immediate closure risk; combined policy changes projected to cost Florida hospitals $4 billion over the next five years.

In response, health system leaders surveyed by Deloitte named regulatory and policy changes their top strategic priority for 2026, cited by 80% of C-suite executives. A quarter of systems have already paused capital investments. Nearly all foresee delaying equipment upgrades and reducing supply budgets.

Theme 3: Patients Are Getting Sicker Earlier and Living Longer

The patient population is aging, sicker at younger ages, and increasingly complex. Medical complexity among patients 75 and older is projected to rise 44% between 2024 and 2034. Hospitals are projected to lose $50 billion annually in revenue as care shifts to outpatient settings. Commercial payer mix is eroding as government payer volume grows. Foundational assumptions — that surgical volume sustains the inpatient business, or that outpatient primarily feeds the inpatient engine — are being challenged by data.

Theme 4: Aging Infrastructure Meets Climate and Resilience Reality

Aging facilities face mounting capital pressure. Florida's hospital infrastructure is particularly vulnerable, as illustrated by images of Tampa General Hospital surrounded by water during

recent storms. Systems must simultaneously maintain aging plants and invest in resilience — backup power, flood mitigation, and supply chain redundancy — while managing constrained capital budgets.

Theme 5: AI Moves from Feature to Infrastructure

Artificial intelligence is no longer optional or experimental — it is becoming foundational infrastructure for health systems. Key data points from the presentation:

- More than 230 million people globally ask health-related questions on ChatGPT every week.

- Global investment in healthcare AI doubled from 2023 to 2024, though 36% of stakeholders report unclear or negative ROI from generative AI use cases.

- Administrative costs have grown at 87.2% — faster than direct patient care — creating large, immediate opportunities for AI automation in clinical documentation, revenue cycle management, and workflow management.

- According to the 2025 Future of Jobs Report, only 34% of healthcare activities will be mostly performed by humans going forward.

Gurley and Meyer called on facilities professionals to design for adaptability — building platforms that can flex as care models evolve, not just places optimized for today's workflows. "We're not just planning for the future," Gurley said. "We have to plan for multiple futures."

Healthcare at the Crossroads: Capital Pressures & Facility Investments

Matthew Bluette, AIA, ACHA, AICP, NCARB, LEED AP, Principal, CUBE 3

Walter Jones, Senior Director and Healthcare Market Leader, Barton Malow

Jennifer Pille, BSChE, MBA, Staff Engineer, Moffitt Cancer Center

Rahul Tikekar, PE, MS, MBA, Principal, Senior Vice President, Loring Consulting Engineers

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

This session was structured as a guided roundtable conversation moderated by Alan Whitson. Alan opened by framing the stakes: persistent financial stress, escalating patient demand, workforce shortages, technological change, and aging infrastructure are converging into what he called a "perfect storm" that is compelling health systems to fundamentally rethink facility investment decisions.

Panelists represented architecture, construction management, owner-side engineering at a major cancer center, and mechanical/structural consulting — a cross-section of the project delivery ecosystem. The roundtable questions Whitson posed to the group included:

From your perspective as architect, engineer, contractor, and operator — what are the two or three biggest levers you can pull to create and maintain a network of facilities that are effective, efficient, adaptable, resilient, and sustainable?

What's your gut telling you about these capital pressures — short-term blip, a 6-to-10-year trend, or the new normal?

How is this affecting the planning for future facilities, and what are the guiding principles needed for long-term success?

What do healthcare systems need to do to keep their existing portfolio of facilities effective, efficient, adaptable, resilient, and sustainable?

What issue, trend, or method is overhyped? What is flying under the radar?

Note: Regrettably A transcript of panelist responses was not available at the time of publication. This summary reflects the session's structure and the moderator's questions. The broader themes of this panel — capital constraints, investment decision-making, and the drive for resilient, adaptable facilities — ran as a thread throughout the day's discussions.

Tips, Tricks of the Trade & Traps to Avoid

Jason Cooper, Area Sales Manager – East Region, Camfil

Jason Cooper, who brings extensive experience working with large health systems on supply chain and operational performance, delivered a focused presentation on air filtration — making the case that in healthcare, details matter, and air quality is no exception. His message was built around three core ideas: a tip, a trick, and a trap.

Tip: Check the MERV-A rating, not just the MERV number.

Cooper introduced the distinction between MERV and MERV-A ratings, a difference most facilities professionals have not encountered. MERV measures a filter's efficiency at the point of installation. MERV-A — the "A" translates to "actual" — measures whether that efficiency holds up over the filter's actual service life under real-world dust loading. ASHRAE 170, the governing standard for healthcare ventilation, requires non-degrading filters — meaning MERV-A performance is the standard that matters.

- Filters can be labeled MERV 14, but only MERV-A 14 filters can actually maintain MERV 14 performance standards after dust loading in a real facility.
- The MERV-A rating reveals which filter actually protects patients, staff, and mechanical systems over its whole service life.

Trick: Select for average pressure drop, not initial pressure drop.

A common procurement approach — choosing the filter with the lowest initial pressure drop — can be counterproductive. Cooper explained that filters starting low but loading quickly strain fans, inflate energy budgets, and accelerate maintenance cycles.

- A filter that stays stable over its service life preserves airflow, saves energy, and keeps HVAC systems operating as designed.
- Selecting for average pressure drop over the full service life is a better predictor of total system performance and cost.

Trap: The lowest-cost filter is rarely the lowest-cost option.

Drawing on his background in procurement and supply chain with major health systems, Cooper pushed back on the drive to minimize per-unit filter cost. A cheaper filter that degrades quickly generates downstream costs — in energy, labor, premature changeouts, and mechanical system strain — that far exceed the initial savings.

- The real value in healthcare filtration is not the smallest price tag. It is consistent performance throughout the filter's service life.
- Cooper's bottom line: measure what lasts, choose what stays stable, and invest in what actually performs. "Understand the difference between price and cost."

Power Under Pressure: Keeping Healthcare Running When It Counts

Ben Fitzgerald, MHA-SI, ILO, CHE, Executive Director, System Support Services, Facilities, AdventHealth

Nate Jones, PE, Principal, Engineering Practice Director, BSA

Sean Lawler, PE, LEED AP, Principal, Affiliated Engineers

James Vun Cannon, National Healthcare Segment Manager, Schneider Electric

Moderator: George Valaes, PE, Strategic Account Executive, Schneider Electric

This session examined the growing role of electrical power monitoring, data analytics, and digital twins in keeping healthcare facilities operational — particularly in the face of Florida's hurricane season. The panel brought together a healthcare operations executive, a facilities leader from one of the state's largest health systems, and an engineering consultant specializing in electrical systems.

How is technology changing how facilities teams manage electrical systems and respond to emergencies?

Fitzgerald: Fitzgerald, drawing on experience managing facilities across AdventHealth's enterprise during multiple hurricane events, described how real-time electrical monitoring allowed his team to proactively switch to island mode during one storm — roughly 18 hours before grid power was fully restored. The decision was based on observing sags and spikes in incoming power that signaled instability. During Hurricane Milton, enterprise-level visibility allowed him to monitor automatic transfer switch activity across the entire Florida system simultaneously, enabling both hospital-level and system-level decision-making. "It's better to be proactive" than to let an automatic transfer happen reactively, he said, noting that clinical staff and imaging equipment can be prepared when the switch is planned.

What additional data sources can improve storm and grid decision-making?

Vun Cannon: Vun Cannon described the ability to integrate external data feeds — from NOAA, NASA, and weather services via simple APIs — directly into electrical power management systems (EPMS), combining environmental data with real-time power quality monitoring. Factors including wind speed, rainfall, flooding, heat, and voltage decay can be synthesized to inform decisions about when to island a facility. He also described the potential for Monte Carlo simulations to add probabilistic reasoning: how often, historically, does this type of storm cause power loss at this time of year? While he acknowledged preferring human decision-making over fully automated responses, he noted that rule-based systems with modeling are now sophisticated enough to reliably trigger island mode.

What is the value of digital twins in healthcare electrical systems?

Vun Cannon: Vun Cannon walked through how a complete digital model of a hospital's electrical distribution system allows engineers and facility staff to simulate current flow, predict harmonics, verify breaker coordination, and run capacity planning scenarios — without touching the live system. He noted a practical workforce benefit: as experienced electricians leave, the digital twin becomes a training and

knowledge-transfer tool, allowing new staff to learn how to reroute power in a complex distribution system before encountering the real thing.

Fitzgerald: Fitzgerald described the industry's broader direction as a shift from reactive to proactive maintenance — leveraging "big data to operate more efficiently, more intelligently, and more proactively." He cited digital twins already being used on building envelopes and roofs, where photographic modeling can track degradation over time with high precision.

How should engineers approach technology decisions and project goal-setting?

Jones: Jones offered what the moderator called "common sense gold" from an engineering perspective. He cautioned against value engineering that strips resilience and monitoring systems from designs to cut upfront costs — arguing that the long-term operational and troubleshooting value lost far exceeds any short-term savings.

On goal-setting, he pushed for honest conversations with owners about what they are actually trying to achieve before committing to costly technology. He cited a fully electric, zero-energy hospital under design in Seattle requiring massive PV investment: from a pure economic standpoint, the owner would have been better served funding a utility-scale solar project. "Does this really make sense?" is the question engineers must be willing to ask.

Lawler: Lawler highlighted the growing prevalence of variable frequency drives (VFDs) across healthcare HVAC and infrastructure — pumps, fans, and beyond — and the engineering demands they create.

Digging deeper, he explained that VFD proliferation has forced mechanical engineers to become fluent in electrical systems as well, particularly harmonic analysis. Harmonics introduced by VFDs can cause premature equipment failure, motor burnout, and bearing degradation — problems often misdiagnosed or attributed to other causes. Recognizing and accounting for harmonic distortion is, he said, a fundamental part of responsible healthcare engineering practice today.

Audience question: How do you justify the ROI of an EPMS to leadership?

A member of the audience asked how to make the financial case for power monitoring investment. Responses from the panel converged on a few strategies:

- Ask the C-suite what an hour of operating room downtime costs, and what a new downtime event would cost — then build the case around avoided loss rather than direct return.

- The linkage between predictive analysis and actual cost avoidance is often lost when maintenance work is handled through informal purchase orders rather than the CMMS system, breaking the data loop needed to demonstrate causality.

- Fitzgerald noted that even a single avoided downtime event can justify the cost of an EPMS system. "We're never going to prevent everything," he acknowledged, "but that's not the goal."

The Evolution of Operating Room Design – Why Early Decisions Matter

Clifford J. Yahnke, Ph.D., Chief Science Officer, SLD Technology

Cliff Yahnke delivered one of the day's most wide-ranging presentations, tracing the history of operating room design from 19th-century barbershop surgeries to AI-coordinated hybrid ORs — and making the case that the industry is still not doing enough to eliminate preventable infections. As chief science officer at SLD Technology, a company founded in the cleanroom industry, Yahnke brought a contamination-control perspective that challenged conventional thinking about how ORs are built and regulated.

The historical arc: from mortality to modern standards

Yahnke walked the audience through six eras of OR design evolution:

- Early Surgery (1800s): No sterility, high mortality, speed over precision.
- Surgical Amphitheaters (1800–1860): Tiered seating, skylights for natural light before electricity, no infection awareness.
- Antiseptic & Aseptic Era (1860–1900): Semmelweis introduced hand-washing after observing that infants attended by medical students who also performed autopsies died at nine times the rate of those attended only by midwives. Pasteur established germ theory. Lister introduced antiseptic surgery — including carbolic acid sprayed above patients to disinfect the air — reducing patient mortality from 47% to 5% over several years.
- World War II Era: The U.S. Army commercialized positive pressurization (keeping OR pressure higher than the corridor to push contamination outward), mechanical ventilation, and temperature and humidity control.
- Infection Control Engineering (1970–1990): HEPA filtration, stainless steel surfaces, seamless flooring, and clean/dirty corridor concepts became standard. OR size grew from 300–400 to 400–500 square feet.
- Smart & Hybrid ORs (2010–Present): Advanced laminar airflow with integrated LED lighting, antimicrobial surfaces, digital interoperability, robotic surgery, and modular construction. OR size now ranges from 600 to 1,000 square feet.

The problem that persists: there is no contamination standard for operating rooms

Despite more than 150 years of progress, Yahnke argued that a critical gap remains: there is no standard specifying the maximum allowable contamination level in an operating room. ISO clean rooms — used in semiconductor manufacturing — carry absolute contamination thresholds. ORs do not.

- Healthcare-associated infections (HAIs) cost an estimated $84–$90 billion annually in the U.S. (2025 dollars), affecting roughly 1 in 31 hospitalized patients.
- Surgical site infections are the most expensive category of HAI. Every patient who develops one must cycle back through the healthcare system, consuming resources and staff time.
- Current infection rates of 1–3% represent progress from the pre-Lister era, but Yahnke argued the benchmark should be zero — a philosophy he called "Design for Zero."

The cleanroom solution: airflow as the primary defense

Yahnke explained the physics of contamination control through airflow, comparing three delivery approaches:

- Four-way throw diffusers and multi-diffuser arrays create turbulence — the swirling, unpredictable air movement that resuspends contamination into the surgical field.
- A single large diffuser, borrowed from semiconductor cleanroom technology, delivers a unidirectional "piston" of air from ceiling to floor-level return grills, pushing contamination out of the surgical field rather than recirculating it. Computational fluid dynamics modeling shows the surgical field is effectively contamination-free under this approach.
- Visible light disinfection systems, integrated into OR ceilings, can reduce contamination by 80% while patients are on the table — and increase disinfection intensity when the room is unoccupied.

Yahnke noted a persistent real-world problem: return air grills in the corners of ORs are frequently blocked by tables and equipment, causing air to recirculate rather than exhaust. "I've been amazed at the number of times I've walked into an OR and there's a table pushed right over the return air grill."

Why early decisions matter: the case for modular, factory-assembled construction

The second half of Yahnke's presentation addressed constructability — arguing that the same early-decision discipline that improves infection control also reduces cost and schedule risk. He outlined the spectrum of construction approaches:

- Stick-built (traditional): Multi-trade, sequential construction with high potential for cost and schedule overruns, scope gaps between vendors, and noise and disruption in occupied facilities.
- Kit of parts: Slightly better than stick-built but still requires substantial skilled labor on-site and does not fully leverage prefabrication benefits.
- Fully integrated, factory-assembled systems: Built on a production line and shipped to the job site for installation. Delivers faster time to market, cost certainty, consistent quality, and reduced construction noise in occupied facilities. Data from the Healthcare Construction + Design conference suggests savings of 20–30% compared to stick-built, largely from reduced contractor markups and fewer required skilled trades.

Yahnke was direct about the skilled labor challenge: "Skilled labor is out building data centers right now, and they're being paid a ton of money." Prefabricated, factory-assembled OR systems reduce dependence on scarce skilled trades while also improving quality consistency across multiple rooms.

The critical enabler, he stressed, is making key structural, airflow, lighting, and boom placement decisions early in the design process — not to lock in vendor choices, but to build the structural framework that allows flexibility later. "The definition of insanity," he said, citing the familiar aphorism, "is doing the same thing over and over and expecting a different result."

Security in an Era of Increased Violence

John Demming, Director of Security & Safety, Lakeland Regional Health System; Vice President, IAHSS

Christopher Fender, BSCJA, CHPA, ILO, CPTED, Executive Director, Corporate Security Services, AdventHealth

Gloria Graham, MLD, CHPA, CPP, Principal Healthcare Consultant, Cosecure Enterprise Risk Solutions

Melanie Wright, CFDAI, CSI, Business Development Manager Healthcare, HID Global

Moderator: Bill Navejar, President, IAHSS Foundation; President, Bill Navejar Consulting Services

Bill Navejar moderated a session on the intersection of healthcare security and design, drawing on practitioners from hospital security leadership, corporate security, law enforcement, and physical security technology. The central message throughout: security must be at the design table from day one, not called in at the 11th hour.

How important is design in creating a safe environment?

Wright:
The most important element is natural access control, not locks and card readers. Incorporating CPTED — Crime Prevention Through Environmental Design — principles into the process from the start reduces risk without costly technology retrofitted after the fact. "Locking the door is not the most important part. The most important part is the design process."

Graham:
Design establishes the foundation for both technology and staff behavior. A mother-baby unit where the visitor registration desk was positioned far from the entrance created ongoing vulnerabilities with no easy fix. Getting layout right from the beginning is far less costly than correcting it later.

Fender:
Design shapes behavior and risk — it either designs problems out or designs them in. AdventHealth created a corporate-level security function specifically to embed consistent security thinking across 59 hospitals in nine states.

Demming:
Security leaders can add value even before the design phase — assessing crime rates and risk profiles at proposed sites using CAP Index scores, giving design and executive teams a realistic picture of the threat environment before a line is drawn.

If the project team were in front of you, what would you want them to know?

Wright:
Bring security to the table at the front end — not at 90% construction documents. Too often the call comes late to retroactively add card readers, creating expensive redesigns. Collaboration from the start is the only way to ensure security is designed in rather than bolted on.

Graham:
Someone on the team should hold a CPTED certification. Facilities are measured not by how they look on opening day but by how they perform on their hardest day. Design with that day in mind.

Demming: Security leaders can provide site-level risk intelligence before ground breaks — local crime data and CAP Index assessments that give the team a realistic picture of what the building will need to manage.

What should designers integrate for cost-effective security?

Demming: Plan for weapons detection now, even if it won't be installed at opening. Account for spacing, power, and entryway flow during design so that adding detection capability later doesn't triple the cost. "Within 10 years, weapons detection will be the norm."

Fender: Prioritize natural surveillance and layer access control in concentric circles that tighten toward the facility core. Engage staff in exterior space design too — a nurse on a 7 p.m. shift will always take the shortest route to the parking garage, and that route needs to be safe and well lit.

Graham: Future-proof every security element. Run wire for access control even if hardware won't be installed yet. "Value engineering out security is always short-sighted — but if it must happen, have the conversation about the consequences so the decision is informed."

Wright: Avoid aesthetics that compromise safety — landscaping blocking sightlines, blind corridors, overly complex systems staff will work around. A workaround means the security layer is effectively gone.

Audience question: AI-assisted weapons screening — how reliable is it?

Demming: Weapons detection technology is advancing rapidly and increasingly AI-powered, but human judgment remains essential. A uniformed officer serves dual duty: secondary screening and warm customer service. The interaction is security and patient experience at the same time.

Graham: Caution: AI camera systems that attempt to identify weapons through video are not yet reliable enough to replace a dedicated detection system. A recent incident where a student was tackled because the system misidentified a bag of chips as a firearm illustrates the risk. "There will always be a need for an officer to make the final determination."

Where is the line between security and a militarized environment?

Graham: It depends on organizational culture and community. The key is understanding what leadership wants the facility to communicate, then designing security to reinforce that culture. "You have to meet people where they are when it comes to their perceptions of safety."

Fender: Body-worn cameras on all officers shifted AdventHealth's culture away from confrontation toward the caring presence appropriate in a healing environment. "People don't come to us on the best days of their lives — we need to be conscious of that."

Demming: Lakeland Regional developed a security customer service plan: warm greetings, clear instructions, respectful screenings, and a thank-you at the end. "You can make it a more secure place without giving people the TSA experience."

How Great Design Improves the Bottomline!

Ramon Cruz, Senior Project Manager, AdventHealth Planning, Design & Construction

Alex Hunt-Branch, Area Manager, Austin Commercial

Mason Mattos, AIA, NCARB, EDAC, Vice President, Florida Healthcare Market Leader, RS&H

Hank Nirider, PE, LEED AP, Principal, Smith Seckman Reid

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

The day's closing panel brought together an architect, a construction manager, an owner-side project manager, and a mechanical engineer for a wide-ranging conversation on what design really means in a healthcare context, how great design culture is built and maintained, and why the earliest project decisions have the largest long-term impact. The session was also notable for its candor — panelists shared real project failures and lessons learned, not just best practices.

What does 'great design' actually mean beyond visual appeal?

Mattos: Design is a form of communication. A lack of intentional design projects apathy, and people feel it. He offered a memorable example: Jeppe Hein's 'social bench,' split at an angle so two people sitting on it naturally face each other, transforming a waiting bench into an invitation to conversation. Small design decisions carry large messages.

Cruz: Great design is ultimately about performance over time. The same budget, same equipment, and same finishes can produce two patient care units that perform very differently, based solely on sightlines and adjacencies. Every step a nurse walks hunting for supplies is a step away from the patient bedside. Design with purpose makes spaces — and the people in them — perform better.

Nirider: A good design is permitted, constructible, on budget, and on schedule — that's the baseline. A high-performing design adds minimal maintenance and efficient systems. A great design is defined by its process: every decision, however small, goes through rigorous vetting in the conceptual and schematic design phase, and the building that emerges reflects all of that disciplined thinking.

Hunt-Branch: From a construction management perspective, great design means fewer change orders, better cost outcomes, faster occupancy, and less rework. Getting the owner into the building sooner is a direct bottom-line benefit.

How do you build a culture of design thinking inside an organization?

Mattos: It starts at the top — leadership must give people the freedom and psychological safety to generate ideas and be heard. Within a project team, that culture means taking the sub's constraints seriously, not just the architect's vision. The goal is a building that "just came together" — where the best ideas from every discipline are legible in the finished product.

Cruz: Culture change begins with who you bring to the table and when. AdventHealth brings IT, facilities, and clinical teams into the room from day one — not at the end when decisions are already made and expensive to reverse. When people have a voice, the dynamic of the room shifts.

Nirider: Keep it simple. Good, better, best scenarios. Present options clearly — he described the ideal decision email: here are options A, B, and C with pros and cons for each, and here is my recommendation. That kind of structured clarity, applied at every decision point throughout design, is what a culture of design thinking looks like in practice.

Hunt-Branch: Construction managers who are brought on early become genuine design partners rather than RFI-generators. The earlier a CM understands design intent and owner needs, the fewer surprises emerge during construction.

How do you integrate design standards while still allowing for innovation?

Mattos: Standards are a great starting point, not the absolute truth. The value is in consistency and predictability for clinical staff — a nurse who moves between campuses should be able to navigate a new unit intuitively. The risk is when standards become too rigid and stifle improvement, especially on the MEP side.

Cruz: Standards reduce risk and create consistency, but they should always be open to validation. When a partner brings evidence from another organization that a different approach performs better, that conversation should be welcomed.

Nirider: Organizations that don't standardize early — especially during a period of rapid growth — end up with multiple campuses running incompatible systems at different quality tiers, requiring higher staffing levels and greater institutional knowledge just to operate. Standardization reduces the knowledge burden on facility staff.

Hunt-Branch: Standards create buying power, quality consistency, and familiarity for construction teams. Repeat clients with established vendor lists enable faster procurement and fewer surprises.

What is the value of physical and virtual mockups?

All four panelists spoke enthusiastically about mockups as among the highest-value investments in any healthcare project.

Nirider: BIM coordination — a virtual mockup of the entire building, built collaboratively with subcontractors — is the primary tool on the engineering side, surfacing conflicts and constructability issues before anyone picks up a tool on site.

Cruz: Physical mockups are essential for user groups who cannot read floor plans. A three-dimensional cardboard model of a patient room or OR, through which nurses can walk and identify where they need outlets, gas connections, or clearance for equipment, yields decisions that drawings alone cannot.

Mattos: Virtual reality has become a powerful tool for users who resist or struggle with drawings. He described a replacement hospital project where skeptical staff eventually lined up to try VR headsets — and, once immersed, began identifying critical issues: where they'd stand bedside, where the family sat, where their rolling cart needed to be. A group of nurses identified a design flaw in diaper-changing space that cardboard mockups then allowed to be resolved before construction.

Hunt-Branch: The investment in mockups — physical or virtual — pays for itself by catching issues that would otherwise become field change orders. The first time a clinical team sees a space should not be the week before patients arrive.

What about pre-purchasing equipment to manage long lead times?

Whitson raised the practice of some large health systems buying major equipment — chillers, generators, switchgear — before projects are even funded, to lock in supply and pricing. The panel offered a nuanced view.

- Electrical gear, particularly switchgear and generators, has seen lead times of 36 weeks or more. Ordering at 50% design development is increasingly standard practice.

- The COVID pandemic and the surge in AI data center construction have both strained supply chains for electrical equipment, making pre-purchasing more strategically important for health systems.

- Mechanical equipment lead-times — air handlers, chillers — have improved but remain a watch item.

- One panelist noted a local electrical engineering firm that has vertically integrated by manufacturing its own transformers, effectively eliminating lead time for that component entirely.

About This Summit

The 5th Greater Central Florida Region Hospital, Outpatient Facilities & Medical Office Buildings Summit was held Feb. 19, 2026, at a Tampa Bay-area venue, and convened more than 100 professionals in healthcare planning, real estate, design, construction, and operations. The event was presented by Corporate Realty, Design & Management Institute and the Association of Medical Facility Professionals (AMFP).

For information about future events in this series, visit squarefootage.net.

AMFP is hosting the IFHE World Congress 2026, co-located with the Healthcare Design (HCD) Conference & Expo, Oct. 17–20, 2026, in New Orleans. For sponsorship information, contact Glenn Fischer at gfischer@squarefootage.net.

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