



Executive Summary
 11th North Texas
 Hospital, Outpatient Facilities & Medical Office Buildings Summit™

May 7, 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

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- How to Handle Growth Without Overbuilding

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Looking Ahead: Healthcare Industry Outlook 2026 and Beyond

Supina Mapon, Healthcare Strategist, DPR Construction

The State of the North Texas Healthcare Market – Square Footage Dallas

Supina Mapon opened by describing DFW as “an interesting case study for U.S. markets” noting that while healthcare construction is being constrained by financial instability, reimbursement pressures, insurance losses, and regulatory changes, North Texas continues to experience aggressive healthcare expansion driven by population growth, stronger commercial economics, and sustained market demand. Mapon identified five major healthcare trends for 2026:

- **ONE | The healthcare math isn’t mathing** – Healthcare systems are facing multiple conflicting pressures simultaneously. Mapon conveyed that hospitals can no longer rely on old financial assumptions or simple cost-cutting strategies to survive, stating, “We can’t cut our way through; we have to grow our way through this... There are no more rabbits to pull from the hat.”
- Mapon emphasized that payer mix is shifting away from commercial insurance and toward government-funded care. The pivot is driven largely by rapid growth in the 65+ population, creating long-term margin pressure for hospitals.
- **TWO | Constraint-driven growth** – Healthcare systems must continue expanding to meet rising demand, but every growth decision is now heavily shaped by financial pressure, workforce shortages, aging infrastructure, climate risk, and shrinking operational flexibility. Capital investment is increasingly splitting into two markets: well-capitalized systems pursuing large-scale flagship projects, and capital-constrained systems struggling to modernize aging infrastructure.
- **THREE | Aging infrastructure meets climate resilience reality** – Facility managers report that more than 70% of health systems oversee at least one building that’s over 50 years old. Mapon highlighted how common aging hospital space has become, calling attention to the clear upward trend in >\$1B severe weather events, and how Texas is at major risk for all three major hazards (intense heat, flooding, and tornados).
- “Texas has experienced 171 billion-dollar weather and climate disasters from 1980-2024, the most in the US,” she stated, emphasizing that severe storm exposure and flash flooding is driving a strategic imperative for more risk-resilient facilities.
- **FOUR | Sicker earlier, living longer** – The chronic disease mortality rate is growing for young adults. Between 2018-2024 the mortality rate for young adults increased by 6.4%. “We’re seeing higher acuity at younger ages. For medical patients, we’re seeing higher critical care days,” Mapon said.

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- She spoke candidly on the accelerating shift from inpatient to outpatient procedures, stating, “We’re seeing sicker patients on the inpatient side, and we’re also seeing more complex care procedures move to outpatient settings faster than healthcare systems can build the facilities needed to support them.”
- Hospitals are becoming more ICU-intensive, while outpatient facilities are evolving into “mini hospitals” capable of handling increasingly complex procedures and higher-acuity patients.
- **FIVE | AI moves from feature to infrastructure** – AI is transitioning from a technology tool to core healthcare infrastructure. Though industry leaders acknowledge unresolved risks, workflow disruption, liability concerns, and implementation uncertainty, AI is still rapidly becoming central to administration in areas such as patient triage, remote monitoring, operations, and chronic disease management.

Healthcare at the Crossroads: Capital Pressures & Facility Investments

Christina Lail, PE, Assistant Vice President, WSP

Hee Lee, PMP, ICBB, CFM, CBO, Regional Director Texas Region, Facilities Management Real Estate, Tenet Healthcare

Charles Shelburne, Senior Vice President, Real Estate, Planning, Design, Development, Baylor Scott & White Health

Sam Werschky, PE, Vice President, Planning Design and Construction, Cook Children's Health Care System

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

What can healthcare systems do to create, maintain, and operate a network of healthcare facilities that are effective, efficient, adaptable, resilient, and sustainable?

- **Lail** – Infrastructure must be designed for flexibility, as program volumes shift roughly every five years. There is growing demand for universal clinical spaces and expansion-ready footprints, since systems that assume they will not grow often eventually do.
- **Lee** – Effective planning must be data-driven and aligned to service lines, with outputs feeding senior leadership decisions. Strategic master planning is essential to ensure execution and adaptability.
- **Shelburne** – Universal care units and efficient footprint management are critical, including right-sizing ORs and avoiding overly specialized spaces. Especially post-COVID-19, staff experience spaces (break rooms, respite areas, collaboration zones, etc.) are also a direct driver of patient care quality.
- **Werschky** – Since 2020, we've learned that navigating the unknown is the new norm. We're focusing more on our maintenance plan for aging infrastructure rather than waiting for something to break down before we fix it. Proactive maintenance over reactive repair allows us to better manage budgets and avoid infrastructure failure.

- **Shelburne** – Beautiful architecture isn't enough. Simplicity is key. Highly customized, single-use spaces limit future adaptability. Facilities must be designed for easy repurposing as care needs evolve.
- **Lee** – Standardization of core systems (e.g., water infrastructure and building systems) enables scalability and reduces operational variability across facilities.

What are your basic guiding principles for long term success?

- **Lail** – Patient care is always first, even on the design side, followed by facility flexibility and protection of existing infrastructure.
- **Lee** – Continuous, day-to-day risk analysis to support operational efficiency and informed decision-making.
- **Werschky** – Standardization. My guiding principle is to look at it through the kids and parents' eyes. We don't want hobbled together buildings. We want one experience as patients move through our building.

How do you keep your existing facilities efficient and up to date?

- **Werschky** – Aesthetics. We don't want to look old. Facilities are managed through a 10-year refresh cycle, supported by intentional aesthetics and data-driven planning. A "swing space" strategy is required as occupancy increases to enable upgrades without disrupting operations.
- **Lee** – Resource allocation must balance appearance with risk management. Critical infrastructure (elevators, chillers, power systems, etc.) requires continuous risk monitoring to prevent failures and liability exposure.
- **Lail** – Catastrophic failures will always cost more than routine updates. Proactive infrastructure management is essential. Focus on routine updates based on data and engineering input.

What trend or method is overhyped?

- **Lail** – Smart buildings. Useful in theory, but not yet supported by sufficient operational maturity or training.
- **Lee** – Electrification. There are still facing too many unresolved infrastructure and implementation uncertainties.

- **Shelburne** – Fully virtual care models are overstated and unlikely to replace physical care environments.
- **Werschky** – Aggressive sustainability timelines (e.g., net-zero goals) risk diverting attention and resources from core patient care priorities.

What is the issue flying under the radar?

- **Lail** – Old infrastructure won't pass inspection.
- **Lee** – Aging infrastructure. No one wants to pay attention to it, but it's a real issue that we've caught up to.
- **Shelburne** – We need more hybrid medical space. Something between a medical-surgical room and an ICU room. We need a place for people who are too sick to be in med-surge but not sick enough to be in an ICU room.
- **Werschky** – For me it's AI. If you're not embracing it, you're going to be left behind – because it's not going to go away.

Money Saving Solutions

Cade Blackwell, Camfil

- Healthcare systems can reduce operating costs through optimized filtration strategy and lifecycle management.
- Advances in hospital-grade filter technology (MERV-A rated systems) enable higher efficiency, longer change intervals, and improved energy performance.
- While filters appear as a small expense, most costs are “hidden” in labor, shipping, and maintenance.
- Upgrading filtration systems can therefore deliver meaningful savings by reducing maintenance frequency and improving overall HVAC efficiency in healthcare facilities.

Crossing the Chasm: From Substantial Completion to First Patient

Katherine Kay Brown, MSN, RN, Operational Readiness Executive, Hammes Healthcare

Andy Craigo, Director, Design, Construction & Project Management, Baylor Scott & White

Ken Hutchenrider, President, Methodist Richardson Medical Center, Methodist Health System

Moderator: Ardas Sabuncuyan, PE, HFDP, Principal, Healthcare Practice Leader, DBR

Summary: The transition from construction completion to patient-ready operations remains one of the most complex and risk-sensitive phases in healthcare development. Panelists emphasized that despite contractual “substantial completion,” true success is determined by whether a facility can safely and efficiently support real-world clinical operations on day one.

Operational readiness must begin with design – not with delivery.

- **Katherine Brown** emphasized that operational readiness cannot be an end-stage activity. With a background in nursing and surgical operations, she stressed the need to involve end users from the beginning of the design process to reduce end-user friction later in the lifecycle.

She highlighted the importance of prototype rooms, mock scenarios, and hands-on training *during* construction, stating successful activation requires “collaboration, cooperation, and sometimes compromise” – especially in standardized clinical environments.

Brown also noted that operational success depends on translating design intent into usability, including detailed coordination of supplies, equipment placement, IT systems, and staff workflows *before* occupancy.

Activation is a relay race – not a handoff.

- **Andy Craigo** described facility activation as a relay race where responsibility must be clearly transferred between teams. Misalignment during the “baton pass” between construction and operations is a primary source of dysfunction.

He emphasized that while substantial completion is a contractual milestone, it does not reflect operational readiness. End users ultimately care about whether the space functions effectively for patient care, not whether the build is “technically” complete.

Craig stressed the importance of defining ownership early, creating structured transition systems, and ensuring clarity around activation responsibilities to avoid contractors becoming default “backstops” for operational gaps.

End users, timing, and governance discipline.

- **Ken Hutchenrider** underscored the importance of involving all end users early and consistently throughout the process saying, “You need *all* people at *all* meetings.” He recommended that every stakeholder participate in initial meetings to avoid misalignment and “telephone game” distortion over time.

He also advised allowing end users to live in the space for several weeks before requesting changes, noting that perspective often shifts once workflows are implemented.

Hutchenrider emphasized formal documentation at every stage as a critical safeguard. “If it isn’t documented, it didn’t happen,” he noted, highlighting the need for signed approvals, structured decision logs, and continuity across long project timelines where personnel turnover is common.

Additionally, he stressed the importance of balancing scope expectations with budget discipline, including having a designated authority at meetings to control scope creep during design development.

Invisible risks: regulation, infrastructure, and timing.

- **Craig** highlighted evolving regulatory requirements, particularly around water quality standards (e.g., ST108) noting that compliance gaps often only surface during testing phases. He also emphasized that regulatory risks could cause weeks or months of delay in waiting for inspections.
- **Hutchenrider** elaborated on the challenge of scheduling state surveys, and how the sequential nature of necessary inspections often clashes with vendor rep availability and is a recurring source of project delay risk.
- **Brown** pointed to training gaps as critical, noting, “no time for training is an invisible risk.” End users need time for both vendor training and internal training, otherwise rushed onboarding compromises safe and successful activation.

The critical role of documentation, institutional memory, and decision governance.

- A central theme across the discussion was the importance of documentation as a safeguard against institutional memory loss.

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- **Hutchenrider** described documentation as the foundation of continuity and emphasized the need for formal recordkeeping across design decisions, operational changes, and rationale tracking to preserve intent across long project lifecycles.

He also described the value of maintaining a consistent “historian” or designated continuity role to ensure that design intent and operational rationale are not lost between phases or leadership transitions.

- **Brown** added that post-occupancy stabilization periods and structured “day-two lists” are essential tools for tracking design intent and change rationales.

Designing for a New Reality: Leveraging Tech to Transform Healthcare Facilities

Ameeta K. Hemmadi, AIA, LEED AP (BD+C), PMP, Enclosure Diagnostics Practice Lead, Walter P Moore

Chadwick Mitchell, CHCPEW, Facilities Maintenance Supervisor, Methodist Mansfield Hospital

Jeff Simcik, AIA, Principal, Sector Operations Leader Healthcare, HED

Mark Williams, PhD, PE, SE, Managing Principal, Managing Director Diagnostics Group, Walter P Moore

Moderator: Jana Summey, MBA, ASSE 12080, Health Care Sector Lead, Diagnostics Group, Walter P Moore

The impact of ‘new tech’ on healthcare facilities and operations.

- **Simcik** – Advanced healthcare technology is expanding clinical capability (e.g., hybrid ORs) and improving efficiency but must be aligned with facility goals and lifecycle planning to avoid rapid obsolescence of tech-heavy designs.
- **Williams** – Healthcare technology is often proprietary and competitive, which causes massive fragmentation. Despite abundant data, processing and integrating that data into meaningful insights remains a huge challenge.

How to keep the continuum of life cycle planning going amidst tech changes.

- **Hemmadi** – Exploring digital twin technology would help us in the maintenance phase, long after the facility is built and throughout the facility lifecycle.
- **Williams** – A key gap is the lack of a “living model” for healthcare projects. We need an evolving, continuously updated digital framework that reflects real-time changes to reduce the need to repeatedly rebuild or reinterpret static archived designs.
- **Simcik** – Success depends on clear ownership and governance for maintaining these models over time.
- **Mitchell** – Without structured transition processes, institutional knowledge is lost during turnover.

Data integration, security, and infrastructure constraints.

- **Hemmadi** – Healthcare data cannot be stored in a single integrated repository. “Systems require governed access controls and strict documentation, with frequent updates needed to keep pace with rapid technological change.”

- **Mitchell** – It can be really hard to keep as-builts up to date, because by the time we install an AI device, it's already outdated.
- **Simcik** – Security demands are driving major organizational change, with 10% of our staff expected to be dedicated to IT. All new equipment must be vetted, cleaned, and processed before integration.
- **Williams** – IT spending has quadrupled, driven by software and memory costs. Supply chain and foreign equipment risks are also rising (there's a ban on foreign drones), making secure procurement and data protection critical concerns. We can't just plug in new equipment and risk data being silently sent to foreign entities.

Reactive vs proactive responses to rapid tech advancements

- **Williams** – The priority is securing and structuring data so it can be integrated. Otherwise, it won't drive action. Also, AI agents and emerging robotics (e.g., companion robotics) in healthcare will likely be good investments.
- **Hemmadi** – Doing the digital twin at conception is crucial. Also, consider the building life cycle. Bring technology in that will future-proof the facility.
- **Simcik** – Integrated, "clean" data systems are essential to enable predictive maintenance, reduce downtime, and shift from reactive to proactive operations.
- **Mitchell** – AI is here to stay, yes, but AI will take a lot of white-collar jobs. Maintenance roles such as electricians and plumbers will become the new white-collar professions. For us, we're using AI to make an MOP in 3-4 minutes when it used to take us 3-4 hours.
- **Hemmadi** – AI may not directly replace jobs – but professionals who understand and leverage AI will replace those who do not.

Cost-Effective Operating Rooms: Design, Construction & Management

Shanda Hatcher, RN, MBA, Clinical Advisor, OR safety & Performance, SLD Technology

Cliff Yahnke, PhD, Chief Scientist, SLD Technology

Standards & Best Practices in the Design of Operating Room Ventilation

- FGI has guidelines for hospital designs – specifically ventilation, and not everyone has reached the guidelines. Guidelines at a glance:
 - 30% blockage over a patient at any given time.
 - Unidirectional airflow and diffusers directly over the table.
 - At least 2 sidewall returns.
 - Return air ~8” from the floor. Return Air in opposite corners.
 - >20 ACH (4 ACH from outside air and 16 ACH from recirc)
- Note that nurses are not taught about low return air grills, and they often put stacks, carts, and trash in front of grills. We need to consider functionality of the guidelines.
- The burden of surgical site infections (SSIs) in the United States is real. There’s an estimated 160,000–300,000+ of SSI cases leading to 400,000+ extra days, higher readmission rates, and lost revenue.

Improve Performance & Constructability

We need to bring clean room technology into the OR. Non-turbulent airflow is essential. With turbulent flow (non-unidirectional) contamination is *recirculated* in the surgical field. But with laminar flow (unidirectional displacement) contamination is *removed* from the surgical field.

- The OR has evolved into a tech-rich, data-driven, infection-controlled environment.
- Construction cost and schedule are critical to a healthcare provider’s bottom line.
- Clean room design and tech can be used to improve performance and constructability beyond what is required by code and standards today (design for zero standard).
- Fully integrated, factory assembled methodology can provide the largest benefits but requires key stakeholders to be involved early in the process to make critical decisions, namely:
 - Determine division and scope: Division 11 for equipment vs Division 13 or 23
 - Make ‘factory assembled’ the basis of design

- Ensure appropriate offset credits (scope leveling)
- Compare costs of modular vs stick-built

Audience question: Is this flexible?

- **Hatcher** – We can provide price certainty, and we can swap out module vendors to suit a surgeon's preference if that's an issue. The only things we really need to get started are TSF, ceiling height, and ACH. Modules are interchangeable and can be swapped out to accommodate size fluctuations.

If you have a shallow interstitial, we can go down to 12". For a hybrid room 14". Standard is 18". We use 10" for old hospitals, but it's not structural. We may not be able to use the boom mount, but we can fit in tight spaces. And if there is a beam above the ceiling, we can shrink our system. We have worked through many engineered designs where we've been able to work with every space.

AMFP is Hosting the International Federation of Healthcare Engineering (IFHE) World Congress 2026!

- 300+ International healthcare facilities professionals
- 4,000+ Attendees to HCD / IFHE 2026 World Congress
- Concurrently with HCD 2026
- October 17-20, 2026
- New Orleans, LA

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How Growth in Specialty Care is Reshaping Outpatient Medical Facilities

Angel Benschneider, System Vice President, Baylor Scott & White Health

Nicki Hellem, RID, EDAC, LEED AP ID+C, Associate Principal, Senior Interior Project Manager, Perkins&Will

Michael Walker, EdD, Director, Development and Acquisitions, Texas Health Resource

Moderator: Ann Atkinson, Senior Vice President, Meadows & Ohly

- The panel highlighted how specialty care is rapidly moving into outpatient environments. This structural shift is driven by population growth, consumer demand, and system-wide capacity constraints.
- **Walker** noted that health systems are “moving our front doors closer and closer to where our patients are” as communities expand beyond traditional medical hubs.
- **Hellem** agreed, saying, “Oncology, radiation, imaging, and cardiology are all increasingly moving into outpatient spaces – and those are complex specialties. Modularity is key.”
- Health systems are responding by developing new real estate models (ranging from free-standing clinics to large-scale health hubs) and leveraging partnerships to scale services efficiently.
- **Benschneider** emphasized that health systems now “grow with the community,” using a mix of PCP clinics, specialty centers, and joint ventures to expand access closer to patients. She added that strategic partnerships allow systems to move faster, lower costs, and scale specialized care more efficiently.
- Growth in specialty healthcare is occurring amidst rising construction costs, workforce shortages, and increasing competition for skilled labor with adjacent sectors like data centers.
- All panelists agreed that data center construction is intensifying competition for trade partners, skilled labor, and real estate, driving up healthcare project costs and worsening workforce shortages. Skilled electricians are especially in demand, with some warning that union labor costs could triple within the next two years.
- Panelists emphasized that adaptability, not true future-proofing, is now the defining requirement for healthcare facilities.

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- **Hellem** noted that universal exam rooms and AI-ready infrastructure create greater long-term flexibility, while Walker stressed that many aging facilities no longer meet community needs, making “reinvent vs replace” decisions increasingly strategic.
- **Walker** noted, “An untapped resource in an aging population may be reinventing Class B and Class C medical office buildings.”
- **Benschneider** agreed, saying, “Construction costs have increased significantly. We thought things would settle after COVID-19, but they haven’t. Currently, new builds, renovations, and demo and build-back rebuilds are roughly the same cost.”
- Panelists discussed growing use cases for AI in trend management, facility lifecycle planning, portfolio management, and operational workflows.
- **Hellem** stressed the importance of retaining human-centered care while exploring AI-enabled tools like copilot systems, rendering technology, and automated scheduling.
- **Benschneider** pointed out that healthcare systems already possess the expertise and data AI platforms depend on. “Within two years, all of us should be interacting with some sort of AI tool.”

How to Handle Growth Without Overbuilding

Laura Geiger Cowley, PE, LEED AP BD+C, Vice President, Program Management, B&H Engineers

Lance Mendiola, CHFM, CHSP, CBO, MS, VP, Construction, Facilities Management & Real Estate, Parkland Health

Ron Pruzinsky, AD, North Pediatric Campus, UT Southwestern Medical Center

Christian Schulke, Administrative Director, Texas Scottish Rite Hospital for Children

Moderator: Darrick Walls, CHC, Vice President, North Texas Region, Broaddus & Associates

- The panel examined how healthcare systems can manage rapid growth without overbuilding by maximizing existing assets, repurposing facilities, and aligning development with local demand.
- **Pruzinsky** emphasized facility assessments as central to repurposing, noting, “We consider value engineering as what the purpose of the building is and what will bring value.”
- **Cowley** called attention to the complexity of preparing a building to be operational again. From roofing and mechanical systems to testing and rooftop equipment, repurposing a facility goes far beyond cosmetic updates.
- To avoid overbuilding, **Schulke** emphasized that good communication needs to be “authentic, kind, valuable, and effective.” He also reinforced the importance of strict adherence to drawings, stating, “Just build what’s in the drawings.”
- Panelists discussed how rising construction costs, labor shortages, and supply chain pressures are reshaping what is feasible and increasing the need for early cost alignment and scope clarity.
- **Mendiola** noted that change orders are increasingly difficult to process, emphasizing the importance of early identification of scope and budget misalignment.
- **Pruzinsky** reinforced cost realism, stating, “If it costs more it costs more. If it’s going to take longer it’s going to take longer. But we need to be kept informed so we can have a mitigation strategy in place.”
- **Pruzinsky** added that population booms are driving pop-up and remote clinics, noting, “Mitigating overbuilding involves better managing your overall portfolio, and portfolios often follow a highway.” He also pointed out that rural healthcare locations may potentially integrate wind and solar infrastructure.

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- **Pruzinsky** emphasized balancing design ambition with operational reality, stating, “We want the biggest and best, but we need the functional and operational. We need our builders to help manage our expectations.”
- **Schulke** emphasized the importance of candid collaboration, noting that clarity and adherence to drawings are essential to avoid downstream cost issues. He added that consultants must be direct yet professional, stating, “Don’t cuss and be kind.”
- Depreciating parking garages emerged as a growing concern, with participants noting their impact on patient experience and reimbursement risk tied to patient satisfaction scores.
- As panelists looked to the future of healthcare construction, **Schulke** acknowledged Texas’ growth. “We’ve been in a 40-year blessed bubble with land, finances, regulation, tax breaks, capital, etc. Texas is so friendly for growth, but we will eventually hit a constraint.”
- Panelists pointed to IFHE as a valuable global forum, emphasizing that future constraints are less about land or facilities and more about physician access and care delivery models.