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

Monday, September 14, 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
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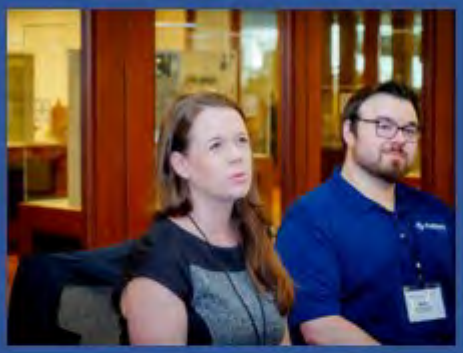


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Executive Summary:

- Healthcare at the Crossroads: Capital Pressures & Facility Investments
- Beyond Buzzwords: Turning Smart Hospital Vision into Practical Reality
- Solution Spotlight: Money Saving Ideas
- What's Reshaping Ambulatory Care & Outpatient Medical Facilities
- The Evolution of Operating Room Design: Why Early Decisions Matter
- Beyond the Headlines: What Hospitals Are Facing Today
- Closing the Chasm: From Substantial Completion to First Patient
- Our Front Line: If These Walls Could Talk

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Healthcare at the Crossroads: Capital Pressures & Facility Investments

Matt Bluette, AIA, ACHA, AICP, NCARB, LEED AP, Senior Principal & Healthcare Practice Leader, E4H Environments for Health Architecture

Erin Bremen, Executive VP, Managing Director, Remedy Medical Properties

Douglas King, Founder, Douglas King LLC

Steve Nargang, PE, HCC, Principal, Practice Leader, Healthcare, Science + Technology, Stantec

John A Orsini, CPA, Executive Vice President and Chief Financial Officer, Northwestern Memorial HealthCare

Cesar Santoy, Principal. Studio ARQ — Moderator

Santoy:	How do you deal with the pressures that are creating a perfect storm?
Orsini:	It's getting much more difficult. We're trying to maximize our available space, make better use of our existing facilities and determining whether we can consolidate services . . . We need a more uniform design, a McDonald's kind of approach. Everything cannot be bespoke.
Bremen:	Medical office is outperforming vis-à-vis different property types such as retail, office, apartment and others. . . Medical office is experiencing a much higher return compared with others and experiencing less volatility as well. The population is aging, and we're continuing to grow well into the future. There's an increase in outpatient visits, while inpatient visits are down 19 percent. And there's a shift in the number of procedures that can be done in the outpatient setting, which will benefit outpatients.
Bluette:	People are younger and healthier, they're greater consumers of health care and they can shop for their health care. The patient is smarter, they expect a different kind of experience that is not so hospital-focused. It has to have a more hospitality-like feel, it's much less costly to build an ASC down the street. Facilities must be brought to where the people are, while more complicated procedures are reserved for the hospital setting.
Nargang:	The building itself gets the attention, and the form and function of the building is top of mind. But much of the cost is infrastructure, meaning the cost of infrastructure has a dramatic impact on the success of the building. You have to build not only for today, but for tomorrow. We can remodel the space three times in a decade. You have to think about adaptability and flexibility when you design a space. Design for flexibility. Modularity helps speed to market, and speed to market is vitally important now.
Orsini:	We build where people live and work. We try to build where it makes sense, where we can maximize what we're building . . . Energy as a service is something we're looking at. There are a couple creative models we're examining as well.

Beyond Buzzwords: Turning Smart Hospital Vision into Practical Reality

Allison Graves, PE, Director of Buildings & Places, JA Watts
Judd Johnson, Vice President, Enterprise Facility Operations and Environmental Health & Safety, UChicago Medicine
Braheem Santos, US Segment Market Leader/Healthcare, Schneider Electric
Dan Naylor, Consultant Solution Architect, Schneider Electric — Moderator

The focus of this panel discussion was on building technologies and how they improve hospital operations, as well as the decisions made with the AbbVie Foundation Cancer Pavilion at UChicago Medicine, a seven-story, 575,000-square-foot facility slated to open on the Hyde Park campus on Chicago's South Side in April 2027.

Naylor: The overarching concept is smart hospitals. What is a smart hospital? There are several hundred perspectives on that question:

Santos: A smart hospital does not waste information that is present. Hospitals tend to be built in siloed approaches. But a smart hospital harnesses information from outside its silo, taking any or all information available.

Graves: In the past, every piece of equipment stood alone and didn't talk to others. Now they are tied together and communicating one with the next.

Johnson: In the beginning of the project, 10 guidelines were established that would be applied across workstreams. Which technologies did we want to apply? This facility is really intended to partner with our research faculty to deploy novel technologies for treating cancer, improving the cancer experience and addressing disparities in healthcare on the South Side of Chicago.

Graves: I've been on campus so long, and have worked with so many parts of the medical campus . . . I was able to start experiencing what was most important for everyone. I got to listen to everything the project team was talking about in terms of what's good and bad, and work from there.

Santos: Avoiding getting lost in the glitz and glamor of some shiny new thing, it was a matter of understanding how it would be used and getting buy-in from everyone.

Graves: We were told we needed to build a cancer hospital that in 35 years would not treat cancer because it would no longer be needed. That's a grand vision. That stuck in our minds in developing a facility that would still be viable 100 years from now.

Johnson: On the owners' team, being the liaison between facilities and the construction team, I lived in both realms. I found that a lot of time folks in facilities leadership positions knew what they wanted and were laser focused on what the spread sheet said and needed me to ensure that was communicated. Conversations needed to be had to avoid a rude awakening later.

Naylor: These conversations can be contentious. Unless there's a moderator in the room, there can be contention and it can lead to less-than-desired outcomes.

Johnson: Choosing a technology partner you can trust is not something you do on day one of a project, but comes about as a result of multiple projects over time. As an owner, we develop key relationships with multiple partners, not just a single partner, which allows us to maintain competitive pricing and stay aware of technologies across different vendors.

Naylor: What is one last thought about an action that can be taken now?

Santos: It's going to come down to people, even as we talk more and more about AI. Everyone has to come to the table and talk about what's best for that project.

Graves: You have to live 5 or 10 years ahead and not be just thinking about today. That's because technology is moving so fast and it will be completely different in the future than what it is today.

Johnson: How do we gather information from 10 years across many disciplines to unlock value? Some f this is straightforward. But you need to think about what you want to achieve across all these disciplines.

Solution Spotlight: Money Saving Ideas

Eddie Villalta, AcornVac

Rodney Weeks, AcornVac

Villalta and Weeks spoke about the innovation of vacuum plumbing, a smarter, cleaner, safer solution for today's buildings and healthcare environments.

Vacuum plumbing provides a streamlined approach, reducing construction costs, construction timeline and change orders:

- The pipe sizes in its systems are much smaller, reduced in size from 3 to 4 inches down to 1.5 inches. This allows the system to work on the same level, eliminating disruptions to floors above and below.
- Air leaks inward, so it doesn't shutdown fixtures up or downstream
- The system also eliminates the "waste bloom" typical of traditional toilets
- Operates with less than half a gallon a flush.

What's Reshaping Ambulatory Care & Outpatient Medical Facilities

Bishan Nandy, Director, Office of Strategy, UI Health
Brian Walsh, CPA, Vice President, Managed Care, Northwestern Medicine
Paul Widlarz, AIA, NCARB, Healthcare Practice Group Leader, Principal, HGA
Kurt R. Lindorfer, SE, Principal, Paradigm Structural Engineers — Moderator

Lindorfer: How does a health system define a need, and define what product they will put into a specific community? Is it by population growth, by changing demographics, what is the thought process in this instance?

Nandy: We need a better understanding of where the patients are coming from, and what their critical needs are in terms of services. That helps us to define our critical strategy at a high level. What services will be offered? And then we look into our patient growth projections, the infrastructure capable of building it and the financial aspect of whether we can afford to build the facility. A tangible program plan should result. Do we need to build new, or better optimize our current assets?

Widlarz: Understanding not just the patient demographics but the competition in the market is important. We have to talk operational goals before we talk sizing. We have to hit the utilization piece. What are our goals from a utilization standpoint, so we're not overbuilding or overexpanding? Will we own assets or employ a third-party developer?

Walsh: We're trying to look at the payer mix, the demographics and who the payers will be. It's cheaper to build an ASC (Ambulatory Surgery Center), but if it is a good location and it will grow our operations, it makes sense from a financial standpoint.

Lindorfer: When you are building ambulatory care, what process do you go through to determine the break points?

Nandy: There is no one size fits all. It's a question of what services would benefit from being in the same location. We did an adjacency analysis, looked into the shared workflows and equipment and that allowed us to map out what should be allocated to what services. If you overestimate the patient volume, you're looking at underutilizing capacity in a very expensive structure and that may not be sustainable.

Walsh: The Medicare Advantage contracts dovetail together. The payers have lots of leverage, and they can make it difficult for us to be reimbursed. So, the higher the leverage we have, the better for us. The payers can't control everything in the market.

Widlarz: You're building for 10 years, maintaining full utilization from day one, but as programs grow you can move certain clinics to other locations, giving you a backdoor strategy for managing success without the cost of overbuilding from day one. We cannot overbuild capacity in an outpatient facility.

It's hard to invest that much in the infrastructure when there is uncertainty at the start. We need the infrastructure master plan. How does infrastructure grow over time so we can have an incremental growth strategy for the infrastructure?

Walsh: Capacity is less of an issue for us, but we will get involved in a long-term planning, saying if we're doing this five years from now, what will the pay mix look like?

Widlarz: We cannot overbuild, we need to be really judicious about where we spend the dollars. We have to work hard to hit that sweet spot. Sometime the location is right strategically, and then you find there used to be a river under this site, so that means 50 feet of fill. Sometimes you get backed into a position you can't back out of. And more and more we're looking at adaptive reuse, often retail buildings. You have to be really aware of ceiling heights and so on. You don't want an inefficient building for 30 years.

Walsh: We find people in the suburbs are not keen on driving downtown, so the fact is we want to keep things closer to the patient because no one wants to drive downtown in the traffic and pay for parking. Keeping things close to our patients is better for them than traveling. We build a facility thinking we'll move a portion of people there, but then the payers disagree. A doctor wants to do a procedure at the academic facility, but the patient says it's way too expensive. We try to take that into consideration.

Lindorfer: What are the biggest challenges of ambulatory care?

Walsh: It's the shifting demographics and the people aging into Medicare where you're being paid a third of what you were paid before they aged into Medicare. The long-range planning around that becomes more and more difficult, and there's nothing you can do. Just because they move from an employer plan to Medicare doesn't mean they want any less care.

Widlarz: Costs are going up, reimbursements are shrinking every day, so from a planning standpoint, we're talking with our clients about optimizing revenue per square foot. How do we drive efficiency and utilization? The kinds of costs we formerly saw in California, we're now seeing in the Midwest. And that is a problem.

The Evolution of Operating Room Design - Why Early Decisions Matter

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

As an operating room nurse for 19 years, Hatcher had the opportunity to examine design through a clinician's perspective. If you're in early with modular design and prefab, she said, upfront costs are higher but total costs are cost neutral or a little lower and projects can be delivered faster.

Hatcher took the audience through the historical stages of surgery, as surgical barbers of the 1860s led to the antiseptic and aseptic era from 1860 to 1900. The era from 1900 to 1940 saw the breakout of operating rooms followed by technological expansion from 1940 to 1970. Then infection control engineering proved dominant from 1970 to 1990.

When air comes down on the patient, but there are gaps between diffusers, and any contamination between the table and the ceiling, surgical infections ensue if the eddies get heavy enough. It takes from $150,000 to $200,000 to treat each surgical infection.

The digital and MIS era from 1990 to 2010 witnessed an operating room evolution with minimally invasive surgery. From 2010 to present, it has been smart and hybrid OR's.

People who build these rooms should know about patient care, not just technology. If you have blood or bone traveling into the light diffuser, patients can see that. We want to design for zero harm in health care. If we're not advocating for a patient, then whom are we advocating for?

As for the impact of healthcare harm, hospitals are spending $12 billion in total cost of surgical site infections. We need to ask what is the performance benefit for patients, not just about the efficiency and speed to market.

The importance of non-turbulent airflow: Placing a single large diffuser equals non-turbulence. So, no contaminants can recirculate back into the system and travel into the gaps.

Create scope clarity, build cost certainty, establish quality standard and improve schedule: All these are the impacts of early decisions.

Pre-fab, fully integrated, factory-assembled, field-installed modules: Comparing stick-built with fully integrated, the latter is faster, offers cost certainty, maintains quality control and provides other benefits, vis-à-vis four different trades coming in to build a stick-built system.

In summary: The O.R. has evolved to a technology-rich, data-driven, infection-controlled environment. Fully integrated systems can provide the greatest benefits.

Audience Question What assumptions do we maintain today that will be found most erroneous within nine years in 2035?

Hatcher: If we continue building stick-built, we will spend five times the money in terms of adapting it to an operating room usable in 2035.

Beyond the Headlines: What Hospitals Are Facing Today

Jordan Powell, Senior Vice President, Illinois Health and Hospital Association

What's at stake for hospitals in Illinois communities? If you've paid attention to the headlines, you know hospitals are under financial pressures. What does that mean when you're working on facilities, infrastructure and capital expenditures?

The challenges hospitals are experiencing in Illinois are also being experienced in other states. Hospitals closing, cutbacks in services, rural hospitals struggling to stay open. Illinois hospitals are losing billions through Medicaid policy change. These issues are going to impact hospitals' decisions on where and how to invest.

Illinois hospitals face looming health crises, with more than 50% operating on thin margins. Powell predicts the problems are going to get worse. The OBBBA represents a huge change in Medicaid policy. It's estimated $57 billion will be lost on federal Medicaid funding. As many as half a million vulnerable Illinoisans stand to lose Medicaid coverage. No longer will the cost of ER be reimbursed. More than two in five Illinoisans rely on Medicaid or Medicare for their health coverage. Yet government payers don't cover the full cost. Every day expenses are rising, and hospital expenses cannot be passed on to the public who use them. The hospitals are absorbing those additional expenses. Bad debt and charity care grew by 25% in the Midwest 2022 to 2025.

Meantime, there is a workforce crisis with Illinois facing a nurse shortage of 15,000. There are not enough graduates to replace those nurses expected to retire. The number one issue the association hears about is workplace violence. Health care workers are experiencing a tremendous amount of physical abuse from the public and patients.

"This is a retention, facilities and safety problem," Powell said, noting the state is projected to have a shortage of more than 6,000 physicians by the year 2030. More than 1,115 hospital beds have been lost since 2019, and 68 of the state's hospitals have cut services over the same time period.

Illinois is the worst state in the U.S. when it comes to medical liability. Professional liability premiums are 10 times higher in Illinois than in neighboring states. This matters when the state's hospitals are attempting to recruit and retain physicians. O.B. is among the leading areas where there is liability cost, the trial lawyers are very influential in Illinois, hospitals are playing defense and are educating lawmakers on the impact on hospital finance. Administrative costs now account for 40% of hospital total expenses in the delivery of patient care.

However, not all the news is bad. Illinois hospital community benefits have increased. They're generating $135.5 billion in statewide economic impact. And 521,000 jobs support working families. So, when hospitals are made vulnerable, there's real impact at stake, in the health of hospitals, services and the communities in which they operate.

What does this mean for the audience? Understand the environment, expect greater scrutiny and be a strategic partner with hospitals. They will not stop investing in capital expenditures. They will continue because buildings age, technology evolves, patient expectations change. But every dollar involved will face greater scrutiny. Flexibility will matter more, as will how they position for 5 or 10 years from now.

Closing the Chasm: From Substantial Completion to First Patient

James J Kokaska Jr, Vice President, Planning, Design & Construction, Advocate Health
Patty Nedved, RN, MSN, former System AVP Planning, Design & Construction, Rush University Medical Center
Mike Schnizlein, Associate Director, Buildots
Christine Strom, Director Planning & Construction, Northwestern Memorial HealthCare
Kirk McKie, Program Director, Indiana University Health — Moderator

Moderator McKie, a neonatal nurse who said she "grew up" at Northwestern Memorial Health Care, noted at the outset of this panel that the previous panel discussion had pointed up why the chasm must be closed.

McKie:	When do you believe activation starts and why?
Strom:	Activation starts when design starts. But it actually begins at the strategic planning stage.
Nedved:	With regard to the utilization, planning and goals, there are too many facilities that are underutilized. "Build it and they will come" does not exist anymore. That preplanning and strategy piece cannot be overemphasized enough.
Kokaska:	As far as Advocate Health goes, we feel there is a very good investment. We built an internal department called the activation team that is a value decision for us, and I can't tell you the countless dollars they have saved and the rave reviews they have received. The activation team is really the glue that keeps process in place. It's really important to keep the true models alive when activating.
Schnizlein:	Bring all the players, the activation players, to the table. That's where everyone understands why we're doing what we're doing, and what the requirements are and everyone's role in the success of the outcome. Having to cut the ceilings apart after completion to correct a mistake is devastating.
McKie:	Design is fun, planning is hard. What have you seen that is really successful in the way of planning?
Strom:	Addressing regulatory approvals should be first. Get ahead of the planning with those teams. Take advantage of the session where everyone's at the table and deciding what your goals are for activation. Get local municipalities familiar with your project space. The more familiar they are with your project, the faster they will be able to give approvals. Don't save punch lists for last. You don't want your contractor doing touch-up work.
Nedved:	Decommissioning is too often missed. You've left a unit and moved somewhere else and there are hundreds of thousands of dollars sitting left in that space. Who accounts for those assets? Who determines that can be saved?
Kokaska:	Make sure your processes for delivery aren't linear. Integrated project delivery has been a huge win for us for the past decade. It's a culture of delivery.
McKie:	When does activation start? It starts in the beginning. The chasm: Construction is part of activation: It is not a separate activity. It's not a process of handoffs.

Nedved: No one wants to go live with their operational leaders taking control. The operators will recognize they thought for a while they could do this, but on top of their day job they don't have the time to follow through on all key readiness points.

Schnizlein: When team members are working together, look for opportunities to steal some time, collaborate with your contractors on how you can work ahead.

Strom: The loading dock is a huge area to manage during activation, it is a full-time job in and of itself, with furniture coming in and doing something.

McKie: We need to be working together. We can't be working linearly. It is not my problem. It is our problem. And if we work together, we are going to lessen the chasm.

Our Front Line: If These Walls Could Talk

Michael Fiore, MPH, CIH, Assistant Vice President, Clinical Operations, Endeavor Health
Janet Lin, MD, MPH, MBA, MHCDS, Chief Strategy Officer, UI Health
John Stiles, Director of Planning, The Ohio State University Wexner Medical Center
Stasia Suleiman, IIDA, NCIDQ, LEED, Regional Healthcare Market Leader, Design Director, Gensler
Michael Schur, AIA, LEED AP, Global Wellness Leader, Gensler — Moderator

Schur: Labor costs continue to rise. There's burnout among employees. Are there design considerations linked to employee recruitment and retention?

At Gensler, we used a third-party panel to look at that question. Ratings of patient care spaces are tightly linked to great work experiences and employee burnout. And the hospital environment has plenty of room for improvement.

Spaces that are ineffective have higher burnout rates. The inverse of that is a great working experience can have an excellent impact on employee retention. Providers with access to outdoor amenities and outdoor spaces face less burnout. The most common amenities are spaces to store, refrigerate and/or heat food. Those are common. The most commonly used amenities relate to food, socialization and phone calls. Outdoor spaces strongly associate with better staff well-being. Parking, cafeterias, cafes, individual spaces to pray or grieve. Most hospitals are not using outdoor spaces.

Schur: How are spaces actually used, versus how they are designed to be used?

Stiles: We opened two facilities, and learned lots of lessons on massive projects. We designed in team rooms, used by physicians in the morning and by ancillary staff in the afternoons. The day it opened everyone rushed in to use the computers, put their kids' pictures up and it was a lesson for us in you can't fight culture. A space was designed in 2017-18, with assigned seats, but there were not enough work stations to accommodate all the new roles that emerged post-Covid.

Lin: We are in the process of a redesign of our intake space. Where can we learn from our colleagues who have designed for the current state but have future proofed design for the coming year? We reached out to those in the city and across the country to see how they have designed spaces. We have taken lessons that you can design for the idea, but it if is not designed well it will not be used, or used for something unintended.

Schur: Are there spaces that have exceeded your expectations?

Suleiman: We are exploring how sound and scent play a role in the patient experience, taking cues from the hospitality or airport environments. Those are the cues I would take now and into the future for planning. Look at aviation, you see music being infused into environments and there's a reason for that.

Lin: I would add color. Engaging the people in terms of the design and space in ophthalmology, because we have seen red is not a color in a hospital space. But scrub colors are the color they are for a reason. Soothing colors may be imperceptible by patients and caregivers, but it goes into the quality of the experience.

Stiles: We spend a lot of time on the details. We changed a lot of things late in the game, based on the feedback we got on patient rooms, and we have 820 of those so it was important we got it right.

Fiore: Fitness equipment more than met its cost in terms of usage.

Schur: What spaces just tanked and what did you learn from that?

Lin: We need space for storage of equipment. What was not accounted for was the type of equipment a surgeon might need and how it could be stored, not in the ER but in the exterior space. So, having alcoves built in would have been great.

Fiore: Access to care and security don't necessarily go hand in hand. Things easily accessible don't give that sense of safety and security to our team members.

Suleiman: We designed a genius bar that wasn't used because the people didn't have the technology, so it was turned into a grab-and-go store. In my opinion, focus groups around this amenity would have been beneficial in deciding what was needed.

Stiles: You want team feedback, but you have to find balance between end users but not get into too much of what you hear.

Schur: What shifts have you seen in your hospital in terms of non-negotiables?

Stiles: We have tried to put in layers of protection between the outside world and where the staff is located, so they know there's a space in between.

Lin: There's a lot more documentation needed, so you need more work stations. Do you want to have a computer terminal in a patient room? It probably wouldn't be used because you want to focus on the patient -- not a screen -- while in their rooms.

Schur: What other spaces have been very worthwhile in appealing to staff?

Stiles: A late-night ghost kitchen for hot meals, and a bus stop so they wouldn't be exposed to the elements in their way into the hospital from the bus.

Suleiman: What I find interesting is respite is usually tied to a physical room for grief support, diagnostic conversations. But in Phoenix, I'm walking through the staff side along a long corridor five football fields long, and it was 6 a.m. And as I was walking, I saw the CEO, kitchen staff, loading dock staff. And what they call this long, long corridor is the Hope Highway.

So, these don't have to be small spaces. They can be long spaces with a lot of natural light. That was something cool and a great lesson learned along the way.

Schur: What are the one or two things that we should pay attention to that we are not paying attention to now?

Stiles: Think about the next generation and the transportation, design in for e-bikes and scooters. And as gas gets more expensive that scooter looks pretty good. It's a huge campus, but digital way finding spaces on the phone. It's not for everyone, but we need the way finding for others.

Lin: Who are we leaving behind, thinking about the marginal people who are not as digitally aware?

Suleiman: Nothing beats access to fresh air. How can we integrate really creative ways to gain access to outdoors?

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