Executive Summary

10th Chicago

Hospital, Outpatient Facilities & Medical Office Buildings Summit

September 10, 2025

Future of Healthcare Facilities

Tackling Aging Infrastructure & Supporting New Delivery Models

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

This Education and Networking Event is Presented by
Corporate Realty, Design & Management Institute
Association of Medical Facility Professionals
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Executive Summary:

- The Future of Space Utilization: Optimizing Healthcare Facilities with AI
- Navigating the Digital Revolution: From Tech Chaos to Cohesive Care Environments
- Money Saving Solutions from Allegion
- Creating a High-Quality Workplace Experience in Healthcare
- Rethinking When & Why We Choose Medical Equipment
- New Generation of O.R.s – Borrowing a Page from High Tech Playbook
- Keynote: What's Next?
- Adaptive Reuse in Action
- Big Healthcare Projects: Managing Scope, Schedule, Budget, Execution & Expectations

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The Future of Space Utilization: Optimizing Healthcare Facilities with AI

Peter Iacobell, MHSA, Physician Group Practice Administrator; Health Strategy and Operations Leader;

James Harrell, Emeritus FAIA & FACHA, Harrell Consulting

Iacobell: When I started it was all about revenue generation. But I also had a question: What adjacencies matter, and how can I increase efficiency, how can I expand or close a location? There are so many different things that can impact utilization of space. Data was siloed, and they weren't put together to track how the facilities performed. The design process was always interesting. Jim said come to us with proposals and an outline. It was totally dependent on the relationship of the architect.

A new paradigm was needed: An informed focus on patient characterizations and needs that drive room scheduling and space optimization in conjunction with provider and staff resources, including patient factors, visit factors and system factors. Ai can be applied to the question of how a patient goes through a healthcare facility. Standardization of data collection enables longitudinal tracking.

Data is the foundation for standardization; "Without data you're just another person with an idea", said [business theorist] W. Edwards Deming. Collect, organize and format data, analyze, integrate and layer new data into projects. What I saw was a shift from a static planning process. It may end up 100 percent accurate, but AI will take it to a different level that is very scalable and not that expensive. Some machine learning predictive analytics in design applications include evidence-driven planning and design, dynamic adjacency modeling, designing for flexibility, life cycle and expansion planning, patient-centric flow simulation for the perfect alignment of patient needs and physical scheduling.

GPT Demo: Iacobell asked ChatGPT a question about how long it will take a patient to be seen. GPT does the analysis. If someone is relatively healthy, they will spend 29 minutes in the exam room.

We asked are there were rooms operating below 90 percent to allow for leveraging internal capacity instead of building out additional space? GPT identified three rooms underperforming by about 40 percent. You get an idea of how to use Open AI to build a data set and really understand it.

Harrell: More robust data can lead to better forecasting of parking, check-in and checkout and waiting areas including type, location and seating arrangement. I'd encourage all of you to sign in to your own ChatGPT and start exploring and testing.

Navigating the Digital Revolution: From Tech Chaos to Cohesive Care Environments

Tripti Singh, Senior Healthcare Planner, SmithGroup

Braheem Santos, US Segment Leader, Healthcare, Schneider Electric

Moderator: Hannah Mitchel, Strategic Account Executive, Healthcare, Schneider Electric

What are the new emerging technologies you're seeing?

Singh: We've seen how ChatGPT has helped providers save time on tasks. Diagnostic tools: AI has the capacity to analyze data and assist in the predictive analytics, and shape the care plans to the unique needs of the patient. Patients are expecting virtual care, quick scheduling and online scheduling tools. That's helping providers push for open communication and building that connection and trust. Smart watch data is sent to your patient charts. All of this is shaping the built environment.

Santos: We're all being asked to do more with less. That's how and why we're accessing data. We're finding a way to leverage data into healthier and more efficient buildings. When it comes to designing buildings, we need to think about how to turn the design over as a digital twin to the operator for efficient use.

Mitchel: ROI is important and in the health care environment you should see that from day one.

Where do you most often see the disconnects between the design teams and the operation teams?

Singh: We all see this every day. The misalignment of the digital workflows with the physical workflows. That's something we see very often. And because of how much the tasks have become digitized, we're seeing redundancies in some of the physical spaces. We need to audit legacy spaces and see how they can be reallocated. Engage the stakeholders like clinicians, and engage them early on in the process so technology can integrate into where the vision is for the project.

How do you plan for digital systems that may evolve or need to be replaced before the building opens?

Santos: Make sure you test in a lab environment first.

Singh: We face this in day-to-day projects. Nothing can be future proofed, but we can be future ready. We try to build that system or space to be flexible so it can evolve as the landscape shifts. With the [number] of advancements, by the time the building is constructed it's outdated. We try to model so we can adopt as the landscape shifts, so we're more prepared, so we're ready.

If there's one thing you'd advise people to adhere to in modern delivery, what would it be?

Santos: Don't lose track of the people. Don't forget about the people in whatever you select. I don't care if it's the carpet, don't forget the people.

Singh: It's all about the human experience. We need to cater to the unique needs of the user group and that should be a priority always.

Money Saving Solutions

Gene Jones, Allegion Healthcare

We are going to share some information on sliding doors. If you've been here before you've seen this presentation. If you eliminate the swing of the door, you can pick up space. Look at some case studies.

- Providence Health Gately-Ryan building in Renton, Wash. picked up three exam rooms, going from 33 to 36 such rooms.
- At the University of Kentucky's Albert B. Chandler Hospital, using sliding doors allowed them to lock and secure these doors to create a safe space.
- Everything you can do with a swinging door you can do with a sliding door. At Memorial Hermann Texas Medical Center in Houston, they're now using a clear 60-inch sliding door in the ICU to overcome maintenance issues with break-a-way doors.

Creating a High-Quality Workplace Experience in Healthcare

Margie Gauthier, Operations Director, Shirley Ryan Ability Lab

Loriann Duffy, Executive Director, Operational Excellence/RESO, Providence

Michael Schur, Global Wellness Leader, Gensler

Stacy Suleiman, Regional Healthcare Market Leader. Gensler

Moderator: Sara Marberry, EDAC, Sara Marberry, LLC

Schur: We want to prep the panel with some thought starters. Gensler is known for workplace research to understand what's happening in different work environments.

Only 38 percent of the global workforce love their workplace experience. Most are craving new and different ones. Workplace experiences are important, amenities are not optional and those experiences impact attitude, attraction, recruitment, and retention.

Suleiman: It's time to think differently about workplaces.

Give us two attributes that would describe a good healthcare workplace.

Suleiman: Restorative.

Gautheir: Innovative.

Duffy: Functional and collaborative.

What are the leading stressors facing employees in the workplace?

Suleiman: The biggest stressor is the absence of relief. The one profession that has not dropped in terms of burnout is nursing. Nurses still say they're at 65 percent burnout. When asked if they would have picked a different career, two thirds indicate they would have done so. This is a conversation we must have, but particularly regarding nursing.

Schur: There's a sense of culture and belonging that's being stressed right now. Being able to provide for patients and families has gained importance. Physical environments must provide support. We must think about the operations. If we provide a yoga studio and it's not used because of the policies that are in place, we need to marry those operational components with the space functions. We can think differently about what amenities are offered. When we think about amenities, it should not be one size fits all.

How important is it to provide amenities in healthy workplaces?

Duffy: If you ask our caregivers, "Where do you want the money to go?" they'll say back to the patients. But if you can incorporate amenities within the community, and find spaces where people can decompress -- whether a chapel or other -- those are important to prevent burnout.

Gauthier: Look at staff space creatively. Some employees want to turn on their music while sitting in the corner, others want to find a place where they can walk around. You need to discover what's important to people in your workplace. You really need to find out what they want rather than thinking you know.

Suleiman: It doesn't matter how great the amenities are. If they are on the other side of the campus, no one will use them.

Gauthier: All employees need to be able to find a private place easily. Why do nurses not eat in the cafeteria? Because they don't have time to get there.

How can buildings help give workers a sense of purpose and community?

Duffy: Being really creative with your space, and finding low-cost solutions, these build community. We had ugly storage containers in our courtyard. We engaged artists who created murals, and people understood these were efforts being provided by the facilities team to make the space more community focused.

With technology being integrated in our work and personal life, is there a way for technology to be integrated into the workplace?

Duffy: By using Epic [software] we're looking for ways to bridge gaps and increase efficiency. Another tool we developed was a translation tool. We have frontline employees who don't have English as a first language, and we vetted this for over a year to make sure the tool was translating effectively.

Gauther: We're looking at ambient documentation. But those devices need to be in just the proper places, so the clinician can connect with the patient, and the provider can be looking at the patient, which is so important to the patient having a sense of comfort.

Schur: Technology is not a strategy. It's an enablement of a strategy. The relationship with the patient and the family member is so critical, because that creates trust. What else creates trust: Is it furniture? Is it technology? It's so critical to be able to test these in a lab to make sure they work and can be adaptable going forward.

How are we leveraging the different channels of technology? Can we monitor the steps of a nurse? And perhaps tell that nurse, "You've been on your feet for a while, it's time to give you a break."

Gauthier: We encourage our patients to move around the building once they're mobile. It was very helpful to be able to track them around the facility. But what was helpful for staff in terms of patients was not something patients wanted for themselves. We can now track patients through wearables in their home exercise programs.

Rethinking When & Why We Choose Medical Equipment

Cathy Gambacorta, RN, BSN, Senior Medical Planner, Introba

Laura Tagorda, Senior Medical Planner, Introba

Gambacorta: A lot of times medical equipment planning is an afterthought, but it should be done in a strategically timed fashion. We think of our equipment in three groups.

Group I: The Built-ins: The major equipment integral to the building, like major imaging equipment, integrated room components and major support equipment. Early decisions are non-negotiable due to such issues as infrastructure clashes and structural changes.

Group II: The Coordinates are no less important. It refers to patient care and monitoring, mobile and portable diagnostics, laboratory and pharmacy and support equipment. The risk of waiting too long becomes inadequate space allocation, insufficient utilities, workflow inefficiencies, minor design adjustments, procurement delays.

Group III: The Plug and Play. These are the patient care devices and more. You don't want to open your hospital with dated equipment. Issues to consider include access to the latest technology, reduced "outdated on arrival" risk, competitive pricing, flexibility, minimal power or network changes.

Excluded categories include Group IV instrumentation, Group V communications systems, Group VI furniture, architectural/other, and office equipment.

The Ripple Effect of mis-timed decisions can be significant.

Tagorda: Why does timing matter? We live, breathe and die by our schedule. When do you need it? We backwards plan from that last responsible moment, and factor all of that into our timeline. We do all the thinking for you behind the scenes.

New Generation of O.R.s
Borrowing a Page from High Tech Playbook

Eric Carlson, Principal/Senior Engineer, TLC Engineering

James Kokaska, Vice President, Planning, Design & Construction, Advocate Health Care

Cliff Yahnke, PhD, Chief Science Officer, SLD Technology

Moderator: B. Alan Whitson, President, Corporate Realty, Design & Management Institute

Carlson: We are seeing a shift toward modular construction. Anything you can build in a factory can be built there more effectively than it can be built in the field. Having something modular you can plug in is amazing.

Kokaska: Speed to market is really important. Even the slightest delays, especially when we have high surgical volumes at the end of the year, are challenging. We feel really good with the prefabricated that we've done all we can in infection prevention.

Yahnke: Our company was founded by someone who worked in clean rooms. The fact that you have a patient on the table with a wound open, with it possible for disease to be presented through air, that's not regulated by any building code. In modular, you can almost always get better performance than in a stick-built application.

Carlson: In adaptive reuse projects, modular prefabricated is the only way to go.

Yahnke: Having ORs built in a controlled environment, you can perform the essential roles: Design, build and test.

What should I look for in an OR?

Yahnke: Now people have to do more with less. When there's an infection, it goes down the hospital system and they don't get paid. Doing more with less has to be reflected in how we build buildings.

Kokaska: You can't put a price on improved infection prevention. As we build more of these in a controlled environment, efficiency increases.

Yahnke: Once you get it installed, what are the testing and maintenance concerns?

Kokaska: There are multiple points of failure in a stick-built system. Our design standards are very important to us to ensure consistency throughout the system. Some of the technologies are fledgling. I really think in the next three to five years our design standards will evolve to make the OR a safer place for our patients.

Yahnke: The most important source of contamination in the OR is us.

Keynote: What's Next?

Tim Fry, Healthcare Partner, McGuire Woods

Moderator: Molly Gamble, Vice President of Editorial, Becker's Healthcare

Fry: What three core themes are you thinking about, Molly?

OBBBA (One Big Beautiful Bill Act), everything in that legislation and how it will affect [the industry]. You see some CEOs predicting doomsday scenarios.

Second, leadership turnover has brought change of control at some really big academic medical centers, and CEO changes sometimes determine a change in strategy.

Finally, the math doesn't work in number of providers serving the number of Americans; you'll see salary increases in the field as a result.

Gamble: What three core themes are you thinking about, Tim?

First, there are a number of states looking to slow down the number of mergers and acquisitions.

The second item is that we had all hoped the economy would come roaring back. But patients are not wanting to come to the office now, credit markets have not come back and there's less equity investing than we'd hoped.

The third trend is something you can call consumer-driven health care, but the move to outpatient is just picking up steam. This is where we have to ask how we can have a health system without the beds we had before Covid.

Gamble: Do you see some of these changes as needed after Steward Health Care bankruptcy?

Tim: Steward Health Care had done a private equity deal and a REIT deal, so that when things went south there was nothing left to address the problem. What happened over the last decade was we did a ton of deals, not just my firm but firms nationwide. All of a sudden there was a kneejerk reaction to try to rein in some of the excesses. U.S. Anesthesia Partners (USAP) had had a private equity investment, and the Biden administration went after that as collusion, and it was a shot at private equity. U.S. Anesthesia and Steward were two of the worst actors. In the Southeast in health care, a lot of states are trying to dial back their certificate of need programs. In those areas, there are great opportunities to build new facilities.

Gamble: Any thoughts on lobbying right now?

Fry: Believe it or not, the Republican party has hated the Affordable Care Act. Fought it tooth and nail. Fifteen years after the ACA, it's impossible to believe there was a time when Republicans congratulated Dems on achieving something they'd long sought, and all the Republicans clapped. Today, there's so much more division you can't imagine that.

Fry: You mentioned regionalization, what's that looking like?

It's not just combining low-volume service lines with a competitor. It's looking across the street and asking to partner to continue service lines in our community. Leaders have grown more receptive to this idea but it's tricky to get doctors to think about partnering with their long-time competitors. Much remains to be seen.

Fry: Will there be changes in strategies with new CEO?

Even if you don't have a new CEO, you need a reset.

Fry: How are CEOs talking to their teams about the financial constraints being faced?

Gamble: We can't talk about wage increases without acknowledging how at the C-suite the compensation has changed. The math doesn't work. There is serious need for better communication and health systems have to get by without what union tactics might have proven effective in the past.

Fry: We're seeing more and more developer-backed medical office buildings and surgery centers being built by developers. These could get the cash flow, but they won't be paid immediately. These are some of the areas where there's been effort to overcome financial pressures.

Fry: Telehealth and hospital-at-home efforts: Are you seeing leader enthusiasm?

This dates back to the mid-1990s and was really touted when capacity was at the max during the pandemic. It was touted as this golden future. But it is not exactly a shining example of our health system, there's a lot that has to be solved there.

Adaptive Reuse in Action

Thaddeus Jedrzejak, CHC, Director, Planning, Design and Construction, Midwest Non-Acute Services, Advocate Health

Chris Martin, AIA, NCARB, LEED AP BD+C, Project Manager, HDR

Andrew Shaw, PE, Senior Associate, IMEG

Moderator: Ryan Yoho, Area Manager, Boldt

Jedrzejak: The project under discussion is Advocate's Naperville Freedom Drive Outpatient Surgery Center. The team has been together thinking collaboratively with a ton of experience and a lot of mentorship, spreading the wealth to newcomers to our project team. We continue to see success using what's there to build medical clinics. This project involved an old LA Fitness facility. It went on the market roughly about two years ago. Advocate got wind of it, as we were looking for a site for cardiac services.

It's a cookie-cutter floor plate, so the question was how do we use it for our benefit?

It was a square box with a large atrium space we had to contend with. A mezzanine also proved challenging. Why did we focus on adaptive reuse? Speed to market, because these existing sites help us deal with challenges of a greenfield site. We can deliver these projects quickly. Cardiology is a high need for Naperville, with Good Sam at capacity and heart patients needing surgery being put on hold six months. This building was less than 10 miles away from Good Samaritan, which really helped us.

Martin: How did we deal with the mezzanine? Starting with the pool we got rid of it. There were really tall exterior windows and in a program like ours a window is not the most desirable thing. We repurposed the mezzanine and tried to make it better but the challenge was it was right in the middle and rested on columns we had to work around. The mezzanine really drove the project. It made sense to put the clinic pods in the area with fewer columns.

The positives of the site included more revenue generating on the main floor, but the disadvantages included columns supporting the mezzanine remained, impacting layouts. Noise impacts of AHUs and mechanical equipment were also issues.

Shaw: There were cost impacts to the use of the mezzanine. Our project started using Building Information Modeling (BIM) from the very beginning. One of the biggest adaptive reuse problems is structure, and trade partners have to be on board from Day One. Laser scanning was essential in the project. We lucked out in that we had ample space to kind of flex. We didn't have leftover space. As for trade coordination, this increased safety because we had fewer personnel, less materials, less waste on site. Anything we can solve on a computer screen via BIM was to the project's advantage.

Yoho: Innovation and evolution of modular prefab. Our mechanical engineers are looking for ways to have components and solutions for many different applications. We decided to do the underground work while we were offsite fabricating our rooms. But that had to be changed as a result of code and other factors.

We prefabricated all the rooms in Montgomery, Ill. They were wheeled into the front of the building, each pod either a single room or a double, and we put them into position.

Audience question: What considerations determine whether a building can be used in adaptive reuse?

Ceiling height and aspect ratio. The benefit of this site was it was a development deal. The developer took care of some things to lower our upfront cost. A prime location just off I-88. The building was originally planned as ground-up construction, but then other considerations made that unworkable. This project would never have happened without finding an adaptive reuse solution. It is wasteful to demolish buildings in good condition, to have that material to go into the waste stream is wasteful, so we will continue to try to find such buildings and do adaptive reuse projects. The project is under budget and on schedule. Years ago, we had a brown field old lumberyard in Oak Lawn, and did repurpose that site into a new ground-up. It does happen but is very costly.

Big Healthcare Projects: Managing Scope, Schedule, Budget, Execution & Expectations

Lynn Murphy, Associate Vice President Facilities Planning at UK HealthCare

Jesse Balock, Vice President Campus Planning & Operational Integration, Henry Ford Health System

Charles S. Cloutier, Project Vice President, Planning & Construction, Northwestern Memorial HealthCare

Daryl Bodewin, Director Strategic Projects/Senior VP, HDR

Allan Ames, PE, LEED AP BD+C, Chief Executive Officer, BR+A Consulting Engineers

Tom Caplis, Senior Vice President/Healthcare Walsh Group

Moderator – Adam Keyzers, Vice President, Jacobs

What common denominators do you look for in putting together a project team?

Murphy. It's not company, it's the person involved. I'd follow Daryl (Bodewin) to any project.

Balok. It's expertise. We knew we were doing something we hadn't tried before, and we wanted to make sure we were bringing in someone who had done something in an urban setting, in an academic setting, over 1 million square feet. Those credentials were really important not just once, but three, four, six times. We needed adaptable people. Our CEO started as a security guard, I don't see too much of that, and that means they know what they know and aren't experienced, so we asked our team to pivot.

Bodewin: We really understand each project is unique. I also like clients that are open to the idea that there will be change happening and that it will be a long journey.

Murphy: The Walsh team has done a great job learning our mindset. There have been a lot of people who've been in Lexington for some time. They've handled these people with kid gloves.

Balok: The challenge we're all talking about is that there is not just a CM and a design firm, we have multiples of those and multiple other partners. So, creating a sense of team is really hard to do. It's hard enough on smaller projects when people are coming and going and you don't see them all the time. But creating that team is a challenge. You're basically creating this mini company that's going to be together for the next eight years, and that is a huge challenge, but something we try really hard to do.

Can you give us an example of team integration and thinking outside the box that has delivered an exemplary result?

Murphy: In-person meetings are integral to making big projects work.

Balok: We brought everyone in once a month. That emphasized how the work needed to get done. It gave people accountability in identifying the

leaders. What we're working through now is what is the flavor of that through construction.

Ames: A big part of this is making sure subcontractors are working with you, staying on budget and consider themselves part of the team.

Caplis: As the CM we had to interview the CA folks, that was an important step in making sure everyone aligned and they integrated in with our teams. That was a victory for us and a big reason that project has gone so well.

Big projects always must deal with the input from the community and management. How does the team deal with these pressures?

Balok: Detroit is a tough place to get a margin. We're one of two remaining hospitals in a city that once had seven or eight. One of the reasons we got through that was all our other partnerships They included Michigan State [University], the [Detroit] Pistons [NBA team]. To develop sites, we had to raise the number of low-income housing units we were developing, and provide educational opportunities for folks in the neighborhood.

Cloutier: Old Irving Park, Bronzeville, when dealing with the city, the city wants to know the alderman is happy, so building a partnership with them is really key. In navigating the 35 agencies you must deal with to get city permits, you need a partner at the top.

Did anyone want to opine on the implications of the Big Beautiful Bill?

Murphy: We are having to figure out how that is going to impact with all the big projects going on. For an institution like ours, it's a big, big deal that's happening.

Balok: A lot of it is our big partners across the country that have been doing this across the country that are reaching out to find partnerships with organizations. Those partnerships are what have us made us successful.

Beyond budget and schedule, what other metrics are crucial to success?

Murphy: If we have a problem with cash, we have six things we can pull a lever on and react. That all does tie in to budget and timing because those are our biggest drivers. When people say, "You have to stop this project," I say, "Whoa, what would you like to pull out?" I went to Tom and said we had to do some work, and we did.

Balok: On our team is someone who's not represented up here [on this panel] and one cost element is IT. And I can tell you that among the problems that occur, IT is way at the top of the list. From smart patient rooms, AI and ambient listening, we have a member of our team ensuring technology is not the afterthought.

Ames: EUI or RFIs. We try to push the energy use down so we can have more money to put into the patient care side of things.

Darryl: Another metric is how adaptable the building is and how flexible it is to meet the needs of the future.

Cloutier: We try to work into the contract a lot of discussion and memorializing of governance. And on the owner side especially that's really important in project success.

Scope creep?

Balok: We plan for those things. At a different level, we've also made some assumptions about what scope those services are delivering. The only real fungible space is flex space in our units . . . as open space allocated to that unit. So far, we haven't had to make any significant changes as a result.

What lessons learned are making the process smoother or saving money?

Cloutier: We have embraced the concept of the parametric model. That's truly been a great way to cut time out of the design iteration process. One customer came out to one of our mega projects and wanted to see the schedule in advance. I said, "Come out to see our six-wide trailer, and to our schedule meeting." It is broadcast because you couldn't get 50 different team members in one room.

Bodewin: Building relationships with your team member is crucial, such as inviting them to have dinner together when they're facing problems so they can mend those fences.

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