Executive Summary

11th Houston
Hospital, Outpatient Facilities & Medical Office Buildings ™
Summit

June 07, 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
National, Regional & Local Sponsors


TMC
HELIX PARK
What Will You Discover?
ELIX PARK


Moderator

11th Houston

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Executive Summary:

- Looking Ahead | Healthcare Industry Outlook 2026 and Beyond
- Navigating Cost, Scope and Complexity of Today's Big Campus Projects
- Tips, Tricks of the Trade and Traps to Avoid
- Hearing the Clinical Voice: Integrating Nurses and Frontline Providers in Facilities Planning
- The Evolution of Operating Room Design: Why Early Decisions Matter
- Future Ready Operations: Why Interoperability is Key to Healthcare Systems
- Behavioral Health: How the Build Environment Shapes Healing and Safety
- Security System Oversights to Avoid When Modernizing Your Facility
- The How Great Design Improves the Bottom Line!

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Reported by Michelle Leigh Smith mediaaware@aol.com

11th Houston Hospital, Outpatient Facilities & Medical Office Buildings Summit Welcome

Gene Jones with Allegion welcomed a full house at Helix Park.

Karen Perucki, Summit Ambassador and Regional Healthcare Director for South Texas with Tarkett, noted Tarkett are celebrating their 160-year legacy anniversary.

Don Hellem with CannonDesign and President of AMFP Houston announced this was the fifth year in a row AMFP Houston has exceeded the previous years' attendance records.

"Our mission is to be the hub where healthcare-built environment leaders share ideas, gain knowledge, solve challenges, connect with peers and shape the future of the industry. What better place than the largest medical center in the world?

"I read an article about world healthcare stating, globally, 1 in 10 patients are harmed during medical care. This is not happening here. Health organizations estimate that 50 percent of this patient harm is entirely preventable with 50 percent attributed to adverse drug reactions or medical errors.

"The other half of preventable harm is why we are here today. What we're here to do today is to educate, share ideas, share our experiences and provide you with additional knowledge. We want to advance the culture of safety."

Healthcare at the Crossroads:
Capital Pressures & Facility Investments

Moderator: *Alan Whitson, RPA, President, Corporate Realty, Design & Management Institute*
Panelists:
Robert Feldbauer, Chief Facilities & RE Officer, Children's Health; AMFP National President
Sunita Ganjoo, MBA, PMP, CLSSYB, Vice President, Healthcare, CannonDesign
Gaurav Khadse, Vice President, Facilities Planning & Development, Texas Children's
Rahul Tikekar, Principal, Healthcare Group Leader, Loring Engineering

Robert (Bob) Feldbauer:

Involved in a new $5B pediatric campus, Bob said the key idea is that philanthropy has become a structural pillar of the capital stack, not just a charitable line at the bottom of the page. "For our pediatric campus, our philanthropic goal is $1 billion, a full fifth of the total. The strategic aspect is that successful systems leverage philanthropy to create margins of excellence: a new campus, centers of excellence, etc., rather than to cover operational budget gaps or losses."

About a quarter of health systems saw a decline in giving last year, even as most grew. He sees this as significant since divergence was the point. He sees capital pressure as the new normal, with no real end in sight.

"I loved the Blackberry, but I learned to use the iPhone because the world moved on. There was no going back. With capital pressure, recovering margins has become much harder. There are 2 to 3 percent operating margins. We're not going back. It's not a 3-to-5-year blip. The problem we see nationally is you have some healthcare systems at the top – the top 20 percent. Then you have the majority middle that are hanging on, and then the bottom tier that is really struggling. In this tier, you'll see hospitals being bought out or closed. The days of cheap money are over. In my opinion, it's the new normal."

Sunita Ganjoo:

Sunita is leading a major healthcare project at AK for CannonDesign. She emphasized the financial pressures facing healthcare organizations are significant and unlikely to ease. "The capital pressures are real, and the underlying pressures are different," she said.

Following 2020, the healthcare landscape changed dramatically, with many large and small health systems merging as smaller organizations struggled to survive. At the same time, reductions in elective surgeries created major revenue losses. "Executives are under pressure to do more with less," she noted. Sunita highlighted the importance of operationalizing new facilities. While significant capital is often allocated to constructing hospitals, organizations must also carefully evaluate the long-term costs of operating them, including staffing, equipment, and ongoing maintenance. Today, the projects that receive approval are those clearly tied to strategic

outcomes. “You have to connect the project to measurable metrics- patient throughput, workforce retention, and market growth,” she explained. C-suite leaders are most responsive when both the financial impact and mission value are supported by data and a realistic implementation plan.

She also stressed the growing importance of adaptability and infrastructure resilience. Facilities being designed today must remain flexible for decades, accommodating evolving care models, supply chain disruptions, and future technologies. Organizations investing in flexible planning, standardized systems, and resilient infrastructure will be better positioned for long-term success.

Gaurav Khadse:

Gaurav leads the Facilities Planning & Development and Real Estate Services team at Texas Children’s; his team is currently working on a Joint Venture project with MD Anderson for a new Pediatric Cancer Hospital in the Texas Medical Center. “Capital pressures are not temporary – there is a long-term shift,” he says.

The entire landscape is shifting for healthcare institutions. There are three ways capital is generated: Operating margin, philanthropy, and debt; all three are under pressure. Expenses are very high and operating margins continue to diminish. Cost of debt is high and that leaves heavy reliance on philanthropy to support capital projects pertaining to growth. Often philanthropy might arrive for an initiative that is not the highest priority at that moment in time. At the back end, it puts pressure on operations and starts squeezing margins again. “This is not a temporary thing – it’s a long-term shift,” he said.

“I was going to mention the example of Kodak.” The entire landscape has shifted. All the large healthcare systems are leaning on philanthropy. The smaller ones look at consolidating. There is a lot of regulatory pressure. From large healthcare systems, we have 100s of buildings that are now aging. It’s very important that the capital goes toward that – there is pressure to make sure your existing facilities are kept up. What can you put towards growth? Lastly, the demographic shifts are large, as well as the shifts of consumerism. It’s difficult to project past a 3–5-year plan.

Rahul Tikekar:

“Reimbursement pressure, labor shortages, aging infrastructure, climate risk, and technology investment - those aren’t temporary headwinds. They’re long-term realities. So I see this as the new normal. The question isn’t when it goes away, it’s how we design and invest differently in response. Capital is no longer abundant, so projects have to prove value operationally, financially, and strategically. That pressure, while uncomfortable, may actually produce smarter facility investment decisions.

“For us as engineers the big thing is aging infrastructure. In terms of energy and energy measures, you want systems that are more efficient and resilient. Do you want to continue working with systems with poor energy outputs? Technology is changing as we speak. Complex systems are integrated into each other whether they are surgery spaces in inpatient facilities or

multispecialty outpatient spaces. Important questions consider: Is your Infrastructure capable of adapting to the rapidly changing technology? Infrastructure has to go in parallel with the design.

“There are three principles that should be followed: First, standardize across the network and stop reinventing the wheel but build in flexibility where change is likely. Second, shift the focus from construction cost to lifecycle cost — what will this facility cost to operate for 30 years? And third, design for adaptability and resilience from day one, because healthcare is changing faster than ever. If we align design, construction, and operations around those three things, we get better performance with less capital.

“In this environment, capital discipline is no longer optional. The health systems that succeed will be the ones that align design, engineering, construction, and operations around measurable performance — not just project delivery. It is important that when an executive team decides to embark on a project in this environment understand your MOSCOW - Must Haves - what is absolutely necessary. Should Haves- these are things that bring in a lot of added value. Could Haves- nice to have but you should think twice in this environment, and Won’t Haves- you cannot have these at all as a part of your project.

RF: On the cost of capital and philanthropy, Healthcare is the top of list for many family foundations. 25 percent of HC systems had giving go down. The ones who continue to be successful are the ones using it for strategic purposes such as centers of excellence, not to fill a gap. On demographics, we have to grow because Texas is growing. Other parts of the country are witnessing a clinical care model that is changing, with acuity going up and more moves to the outpatient center. We adapt, as we consider how to best wisely use the capital we have to continue to serve our community. He also uses the Digital Twins strategy of predictable examples versus real outcomes, showing how healthcare facility leaders can advocate for capital investments by building the business case and demonstrating ROI.

GK: Getting the money is challenging but healthcare systems rely more and more on philanthropy. They are often not aligned with the strategic needs. You know there is a long-term goal of the institution. Often you get philanthropy coming in for the wrong thing. At the back end, it puts pressure on operations. It starts squeezing your margins again. There are regulatory changes that continue to compound the pressure. For large healthcare systems, aging infrastructure with a backlog of deferred maintenance continues to be a concern. The demographic shifts, reimbursement changes and shifts in consumerism remain key factors that contribute to the shift as well. The changes are rapid and projecting past a 3–5-year horizon remains challenging.

RF: Bob recalled the first time he was on a $100M project was 2002. “Now I’m dating myself. You look at labor, competing with data centers for electricians, you look at technology and trying to get the capital for that - none of that is going away. You really have to look at your care model. It’s ok to have the Inpatient towers, but how do you design that wisely so it can meet the needs? You have to consider the outpatient centers. It’s just outrageous the numbers you are dealing with.”

Moderator Alan Whitson: *QUESTION: How do you get the board to cough up the money?*

RF: It's really about your strategy. As facility leaders within healthcare systems, there are things for which we should be advocating. There's a lot of money that goes into keeping up with your energy needs. Things that we are implementing, like digital twins, the business case and the ROI, for infection control. We have to support the strategy team and always be looking at what we can take to the board with ROI to drive down costs. The ones who continue to be successful are using it strategically like centers of excellence, not to fill a budget gap.

GK: Typically, it's not the strategy team driving it. Often numbers are made up. The facilities team must insert self. How many exams room? How many operating rooms? And the most important thing? You are looking at 18-month timeline. You cannot do it in three months. Putting the right facts together for the board is critical. The costs are getting higher. As capital planners, we are the third largest spender.

RT: We calculate based on dollar PSF, but if it comes in at 900 PSF, that has to be factored in. Do the feasibility study. With the tech, and digital twins, those are at the top of energy consumption.

SG: Many projects being delivered today were conceived 5 to 10 years ago under very different conditions, when the funding model was different. Since then, construction, labor, equipment, and operating costs have risen substantially. Meanwhile, healthcare systems are expected to modernize facilities, adopt new technologies, and improve resiliency. As a result, she sees greater emphasis on phased implementation, flexible infrastructure, outpatient decentralization, and projects that deliver faster operational returns.

The Evolution of Operating Room Design – Why Early Decisions Matter

Panelists:
Mike Cloud, Project Executive, JE Dunn Construction
Nupur Gupta, AIA, NCARB, LEED AP, Vice President & Senior Medical Planner, HKS
Shanda Hatcher, RN, MBA, Clinical Advisor, OR Safety & Performance, SLD Technology
Cliff Yahnke, PhD, Chief Scientist, SLD Technology

Cliff Yahnke:

Hospitals make money in the OR and lose it in the ER, great seminal moment of the antiseptic revolution. Then, the US Army made innovations that led to rise of infection control engineering. Surgeries started in barber shops, with a shot of whiskey and a rag in the mouth to keep people from screaming out loud. They focused on speed over precision because of blood loss and pain tolerance of the patient. Surgical amphitheaters were popular before 1860 and existed to help educate the medical community about how to perform surgery. Those rooms had large skylights to allow enough daylight so people could see. Remember, this was before the advent of electric lighting, and they were trying to educate population about surgery.

Dr. Ignaz Semmelweis (1818-1865), a Hungarian physician in Vienna, introduced antisepsis into medicine. He noticed that infants being treated had 9x greater mortality rate than infants treated by only midwives. He realized his residents were performing autopsies as well, in the 1800s, no one talked about bacteria. He introduced idea of washing hands.

Pasteur (1822-1895) (germ theory) introduced further advances in 1863 with pasteurization and focused his studies on sterilization and a then new science of bacteriology. Lister (antiseptic surgery) 1660-1900. Instrument sterilization begins in 1867. Reduced clutter to limit infection risks. The septic property of the atmosphere depends not on the oxygen or any gaseous constituent but on minute organisms suspended in it.

Today, stainless steel surfaces, laminar air flow, and larger rooms contribute to the cleanliness of medical facilities. Yahnke shared some of the properties of the Smart hybrid operating room, LED lighting (reduced heat), Visible Light Decontamination (continuous decontamination of the environment while occupied). This makes it safer for robotic surgery, as did clean room technology and modular prefabricated construction.

QUESTION: What are the early decisions to be made?

Nupur Gupta:

80% of people would like key decisions made early, at the front end, so that it can minimally impact the construction timeline. I've seen that about 10-20% of the decisions impacts 80% of the construction outcome. Selection of the equipment, what kind of clinical needs, what is the

circulation, what is our integration system. Those are the key questions so we can ID the key elements. The other perspective is how futuristic the OR needs to be. There is the adaptability aspect. If the table stakes are not taken care of early on, there's very little room for flexibility.

Mike Cloud:

From a contractor perspective, it's hard to claw back dollars from the subcontractors after bidding. The hidden costs – such as lost time during the VDC period (Virtual Design Coordination) that comes in after final construction documents. These are wasted efforts and trade contractors build that into their budgets. Anytime you can add some certainty to your schedule it also provides certainty of cost. In a perfect world, you find a turnkey partner in lieu of piecemealing multiple trade contractors to create a product. You can mitigate risks and accelerate the schedule. Adaptability during projects is crucial. For example, at UT Southwest Children's Project, a project that will not be occupied for another 5 years, think about all the medical technology that will change in that time. Having that adaptability to your systems is worth considering on the front end. I'm a big advocate on moving component fabrication off site. You get certainty of quality and schedule, eliminating some of the uncertainty toward the end of the project.

QUESTION: The one thing we hear is the four-legged stool – architect, owner, contractor and engineer. How does that work for you?

NG: With plug and play models, different components of prefabrication have been really successful, especially with the ceiling system. It provides the flexibility of innovation. Your ceiling is very clean so switching the room is quicker. There are also modular panels in the OR which have been successful – you can replace if there's a need for a gas change. That quick turnaround for future needs really helps.

Shanda Hatcher:

I was an OR nurse for 19 years, so I'll speak from a clinical standpoint. I'm also working with JE Dunn in Sugar Land. The standard ceiling system is 18 inches, but it can be shrunk to 14 or 12 inches and still hold all the lights and booms and monitors. We can help up front with modular ceiling systems that may be moved, with a 5-year depreciation schedule.

QUESTION: How does performance matter?

SH: When I left nursing, my goal was to work for a company where I could impact patient care. We're here to create safer spaces. I think we're missing a huge step if we just look at dollars and cents. If we aren't looking at protecting the nurses and doctors, we're not really building for patients. I'll leave you with the example of the intuitive robot. What happened is: The first hospital said we'll do it. The younger doctors could do it because they were used to video games. Now how many robot rooms are there because someone said there's a better way to do it? Patients are going home earlier. They can do two more surgeries a day.

NG: In addition to patient safety, it is important to think about standardizing the room so there is less human error. If you have six OR rooms in a row, traditionally we would customize based on doctor's requirement. Now we are designing with eye to patient flow, you eliminate some of that directly impacts the patients' safety.

QUESTION: What would you choose to do differently?

SH: In looking like a technology like this, there are hazards in the OR today, for example, with all of the cauterization that takes place, and the smoke it creates. You breathe that, and now the research shows that breathing that smoke causes infertility in women. I was in my early 20s and struggled with infertility. Several anesthesiologists I worked with were going through infertility as well. I'm proud the tech exists to help with that. I now have three children. If we can find a better way to bring air over patient, then we are helping the majority of the people in that OR who are women."

NG: From design standpoint, the one thing I believe is always the larger size is not the better way to go. It can be a 700 SF room that can outperform the 800 SF room. The flexibility in the plan of spaces and ID the future aspects, the mobile radiation equipment, so having those discussions early on, adapting the room so you can integrate all these systems will help. "I'm a big advocate on anything you can fabricate off site; you get more certainty which drives certainty toward the end of the project.

Planning, Building and Sustaining HC Environments: Lessons from the TMC

Panelists:
Ann Atkinson, Senior Vice President, Meadows & Ohly
Kristen Kupperman, Vice President, Design, Construction + Facilities, Texas Medical Center

AA: *QUESTION: What lessons have stayed with you?*

KK: It teaches you how to work with multiple stakeholders, we work with architects, the amount of people we touch in this ecosystem is insane. As a contractor, it teaches you patience, to understand the problem someone else is trying to solve. We're always proving we can do it bigger, faster and continuing to break barriers.

AA: *QUESTION: How much land does TMC own and where does the healthcare step in?*

KK: Our campus is quite large. We sit on 1300 acres, and we don't own all of it. We have different agreements, ground leases and member institutions are able to build out their spaces. We're a massive HOA, we do the landscaping, own creative lab space, and some office space. We have $5B with Dallas Children's. When you look at successful projects, we don't always completely align with what our Infrastructure needs are, but we do try to make strategic decisions to see what we are lacking.

Helix Park is a prime example; we started 10 years ago. We needed more conference room space, more food and beverage. Everyone needed more, down to our parkers. Early decisions are key, but you also need collaboration, so it doesn't get bogged down. We are a lot stronger as one TMC. This (Helix Park) was the Brown parking lot 10 years ago.

How do we take a massive parking lot and build a hotel and residential and conference space? It's not just TMC decision. We went out early to different partners, we dreamed up our vision, our partners do change, do come and go because it might not be a great fit for them, the mission is always behind the headlight.

AA: I understand TMC used to be a swamp going down to the stakeholders to make sure you are aligned on what the mission is. You need the buy in from everybody.

KK: There are 10M patient encounters annually at TMC with well over 100,000 employees, and we are larger than downtown Austin.

AA: *QUESTION: How have you found the most difficult stakeholder conversations? Are they about $? Can you do it well, can you do it on budget? Can you do it on time?*

KK: You always get negative feedback from those not in our world, but for the early buy in, you have to have that early and manage expectations. It's hard to continue to build at the speed of

everyone's expectations. The only constant at TMC and every institution is change. It might change because there's a new president. If you aren't nimble, it can hold you back.

AA: *QUESTION: How do you create alignment w your stakeholders? What helps someone migrate from being a vendor to a partner?*

KK: Being open, honest, having really good partners, I know it's truly a partnership. I get the random late night phone call, it's the teams. Trust, understanding that it's not always our call. We have boards we report to. If you don't understand how the systems operate, it can be difficult. I come from the GC side; I've been in the trenches. We set up success early. You do that while you manage the different priorities of the district.

AA: *QUESTION: Can you give us an example of when the district priorities were not aligned and how did you overcome misalignment?*

KK: It comes down to patient care and looking at everyone here – the true healthcare heroes, Covid is one of the best examples, but we ended up coming together and collaborating. We're fortunate we are mission-based. We are here to advance life science. I think people have seen CEOs come and go, but the mission stays the same, how do you deliver great care? This project was delivered in 2023, on time and on budget.

AA: Let's educate the audience on what you wish they understand about the pressures TMC is facing.

KK: With IH funding, I think for me the biggest thing is I go to the design teams, it's time, money and effort spent that sometimes never comes to fruition. The tenant decides to go somewhere else. Priorities change so rapidly.

AA: *QUESTION: Capital Stewardship – every Healthcare system has a need for more capital than they can possibly access. How do you handle this?*

KK: It's early planning. HC changes so much, it's hard to know if exactly what decision you are making is right. Try to future proof. Try to build enough so you can pivot. Think about closer generation space. When you build in Life Science, earlier we would have jumped on a $B project, now you hear about $2-3B projects. Who can handle it without it being a JV? You'll see projects delivered with innovative approaches. Push clients to think about project delivery differently. All consultants need to be in the room to set up for success.

AA: Anne used the example of the Duke/UNC collaboration, when two dominant health systems formed a joint venture to best address the pediatric needs in the region. They had been fiercely competitive systems but recently announced they are partnering to build North Carolina's first standalone children's hospitals. Big strategic joint ventures are the future!

QUESTION: How do you distinguish between needs and wants?

KK: Look at what the voids are. I want so many things for this campus. I go back to the mission base and what puts the mission at the forefront. We're fortunate at who leads. I like to say I'm a dream builder for our CEO. It's looking at what we need and where we are going.

AA: *QUESTION: What about Infrastructure, parking lots, common spaces, all owned by TMC?*

KK: Our streets, we focus on water resiliency, how do we continue to improve, we touch every tree, sidewalk and brick. We'll have a car crash through a parking lot on Friday; we'll have a chicken in a parking garage on Saturday. You must look long term when you evaluate investments that might not show up on next year's sheet. I used to look in 5-year chunks, we're in 0–3-year mark, I will try to spend every dollar I get in my budget. We're constantly forecasting and looking at the models.

AA: *QUESTION: You mentioned Hurricanes Harvey and Allison. How has the conversation changed since Harvey?*

KK: We all saw how much money and healthcare was lost; much has been put in place since those storms. From a facilities standpoint, so we can help each other out. If someone needs to pick up a shovel, they are always willing to do that. We are always talking about hurricane proofing. You get to rely heavily on your partners.

AA: *QUESTION: You balance that with new towers going up and aging Infrastructure. What are we underestimating about that?*

KK: There's a risk, high winds, the partnerships we have, we are always on standby for each other, asking do you need any help? Pre or post storm, those are the partnerships to be thankful for in an ecosystem like this. I'll get phone calls from our consultants asking if we need help. We do have tunnel systems for our parking garages – both existing to brand new. We will shut garages down when bayou gets to a certain level.

AA: *QUESTION: Ten years from now, what do you hope people will say about TMC?*

KK: I think Helix Park II shows that Houston architecture can be beautiful. I hope they continue to walk in our parks.

Why Growth in Specialty Care, EDS & Hybrid Models is Reshaping Medical Facilities

Moderator: *Don Hellum, AIA, Senior Project Manager, CannonDesign, President, AMFP Houston Chapter*
Panelists:
Nicole Cummings, Senior Director Campus Planning, The Vertex Company
Donald Feld, Program Director, Healthcare Design, University of Texas Medical Branch
Marissa Vasquez, Senior Director, Design and Construction Projects, Houston Methodist

QUESTION: What was your campus strategy to decompress for the specialty care services?

NC: The point is to get the care where you live. People want it right now, really close, so they can get in and out. The philosophy is to get it to you in your neighborhood. A lot of people are intimidated and won't go to the doctor if they know they have to go downtown. We want people to feel comfortable with healthcare. If we can take those facilities out of the main campus, we can use the facilities for more patient beds.

DF: UTMB is an academic setting – parking is a big problem because we have so many students and patients, we've gone up to 6 parking spaces per 1000 sf, we are actively moving the ambulatory clinics to make way for ORS, one of my projects now is the prison – Hospital Galveston. We just received huge funding from the state to do Infrastructure upgrades, create more beds. We just had a successful project creating a new clinic in Friendswood and expanded our specialty care. Combining ambulatory and specialty care in one space.

MV: We've all built satellite facilities. It's convenient for both patients and staff. We actually started this journey at Houston Methodist with the first Breast Center and the first Emergency Care Center at Kirby over 15 years ago. I was fortunate to be part of those design projects. We still utilize some of those modalities. Our newest care model is not just getting primary care physicians out to the community, but we've also expanded to specialty care clinics. We just recently opened The Cinco Ranch clinic. Houston Methodist Physician's Organization has more than 40 locations between primary and specialty care and Houston Methodist Hospital has 20+ ECCs and Imaging centers out in the community. Together, we have over 1800 physicians on staff to help with that.

For the satellite facility, it's that cost vs. what do you do with the old facilities on main campus? If someone can define what a low-cost facility is in healthcare, I would appreciate knowing that! Designing and building a new hospital takes us 3-5 years. By the time we build what we thought we needed, we're already short. In Cypress, Methodist was fully occupied within a month, so we are expanding now. We're opening 8 Observation rooms next to the ED next week, 40 new beds are coming in October, and another 40 in January. It's a good problem to

have. Because of the retrofit requirements, extra fire alarm, gases, and generators, sometimes existing buildings are not always the best use of your money.

IT requirements are also very different to support innovative technologies, costing as much or more than other retrofits because of redundancies and dual networks. The outpatient surgery centers are not for every patient. Higher acuity cases must still be seen at the hospital. Those are also things we have to weigh in.

NC: Specifically, we do build the things off campus because it is cheaper. I've designed 36 over the last five years. Let's find a piece of land, something we can demolish. Shell space is one of the things we've pushed for. If I build a free-standing ER, I'll build a two-story building. I may not know what's going in at first, but I know the demand will be there. We did the same thing for the oncology buildings we build, where the imaging equipment is there. It's so much cheaper to build the occupancy out in neighborhoods. I can build 100 beds in the neighborhood vs. 20 on main campus.

The philosophy is you either go to the ER or the urgent care track; we wanted you in and out if you were urgent care, and in two hours if you were ER patient. We want you to know you will be treated quickly. Let us refer you to a specialist.

MV: We actually don't have urgent care centers; we have Emergency Care Centers. Our concept was to decompress the ERs, but it hasn't quite worked out. It ends up being a funnel for more patients to go into the hospital. We did look at the idea of Urgent Care/Emergency combined but it didn't make sense for us. Instead, now we also offer same day clinics too.

I recently read an article about our generation, and how many of us are caring for our parents and kids at the same time. We tend to put off our care to take care of their care. However, it is important to find issues like diabetes or a heart problem early. Please take an hour for yourself and make sure you get your doctor's appointments.

DF: Your first call is to your insurance company and make sure they are in network or out. UTMB has a different direction – our leadership would like to keep ED at front door of hospital. The specialties can be drawn down to the ER. It's all right there. We have a different model. We'd prefer to keep same day, urgent care closer to our patients and then our ED's close to the heart.

QUESTION: Have you increased your market share?

NC: Yes, I go to Salina, Prosper, other towns of similar size. It's one of the growth models.

QUESTION: Mark Stewart of Harris Health asked about psych intake in facilities. Can you speak about the impact of behavioral health psych?

NC: We always allow for that. I've designed ERs with rooms for behavioral health patients. It's more about what the immediate problem is, than transferring them to a psych hospital. We deal with it, we're seeing more of it, but for most ERs, it's treat-and-transport.

MV: At Methodist, we have psych holding, we have exam room that can transfer to psych, you hide all the cords, we do 1 on 1, have a sitter with them until we can stabilize them enough to transfer them to a facility that specializes in psych.

DF: AT UTMB, we don't have any in patient psych, we have to transfer out.

NC: At Baylor, Scott, & White, it's normal room but we can roll down the door. What rec's do we have for our rural communities? Marissa says we are going through exploration because we cover a big chunk of Houston, so we have some opportunities as we see more people moving in. We are having high level meetings on what to do next, with all the medical innovations coming down the pike. I don't have an answer now, but we will.

Moderator Don Hellum: *QUESTION: is there a plan for growth in Houston or SA?*

NC: I work all over the country; in Dallas we are with Methodist. It really depends on the health system. We have 9 in Florida with University of Florida, 2 in Okla with University of Oklahoma. You don't see our name on the facilities I design; it's just our model. It's really about that health system.

DF: Our real estate dept found building inside a rental facility is more expensive. Let us build it. The specialty clinics we create – the radiology, the procedural spaces. We are backfilling a lot of shell space. We're trying to push some of those ambulatory things out to make way for more acute care. We do not have an ambulatory surgery center.

It's our leadership's push now to make sure those patients come to a campus so they can be immediately admitted to a bed if more additional care is needed. Houston Methodist has ASE's on Bissonnet, one at Clear Lake, one at Sugar Land – the patients are close to the hospital so they can be transported and if there's any risk, they do get transported – this is for endoscopy, knee replacement, very strict patient protocol reviewed by multiple people. It's helped but it has not solved it.

NC: On strategies for specialty care? At Baylor, Scott & White, we are combining as many as we can, we'll build an ASE, but it will have imaging and also be a wound care clinic. In a sense it becomes a micro hospital where you can do everything except overnight stay.

MV: We've all built satellite facilities. It's a convenience for your staff and patients. One stop shop.

DF: So, the strategy is working, has it proven to have better patient outcomes?

NC: It has, one of the other concepts is we are doing retail space there as well, so there's a restaurant, it becomes a whole neighborhood. Patients and neighborhoods love it. They can stop by Starbucks on way home.

QUESTION: What can contractors/engineers bring to support you?

DF: We're not intentionally pushing patients away from the hospital. The future of combining orthopedics with radiology, now all of a sudden, it becomes outpatient radiology as part of that patient journey. Patients don't like coming to the hospital. They don't like crossing other patients in the hospital. If we can get those services out in the community, its's a win. Help us with the design of the clinics. Help us get everything we need in there, along with shell space. More than 38% of the HC spend is going to outpatient facilities. More and more technology is advancing us to that setting.

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

Moderator: *Debbie Gregory, DNP, RN, FAAN, Owner + Principal, Healthcare Innovation Consulting, SSR*
Panelists:
Jennie Evans, MBA, RN, EDAC, LEED AP, LSSGB, Principal, HKS
Kristen Nordenstrom, BSN, RN, TCRN, Nurse Manager, Emergency Services, UTMB Health League City Campus
Stephanie Reece, Regional Healthcare Leader, Gensler

Stephanie Reece:

One of the first shifts is moving away from clinical input, so it becomes clinical co-ownership and clinical co-design. We should bring them in way before. When you have that, your front-line staff understand the challenges, and they can help get you 90 percent of the way there. It becomes their baby too. Implementation will be so much more successful. Instead of asking them to react, I find one of the greatest tools is shadowing. That is incredible. Taking that into small group meetings, simulating, trying to create that space. I see friction as one of the greatest sources for innovation. Using that to see where the friction is and let's innovate and move the industry forward.

Kristen Nordenstrom:

In response to which tools work best to communicate between design team and staff, emergency nurses do not like change. They can get very frustrated. We have a meeting 2x a week with renovation team, I get on with the team, I talk about what will go on that week, what are the delays, I put it out to my charge nurses. We also have a construction corner that we put up in the breakroom, so they are in the know. When they know the why, they are happy.

Jennie Evans:

It was also a learning curve for the architect. What I can do is translate what the clinicians are asking for to the architect? In Florida, we had many geriatrics, the architect was not budging on his planning, finally I said look, they have a lot of geriatric patients with longer stays. Here's the most important point – the nurse is trained to advocate, that was an early on story. Now we talk about nurses collaborating with developers in the leading phases of design process. I've led several phases planning over 1 million SF and it's been very successful.

QUESTION: With Nursing Healthcare design, CannonDesign's Sunita Ganjoo asked besides working 36 hours straight, what else can we provide from design community? Besides shorter walking distances, what else internally can be done about burnout? Other than the design community coming forward, what can be done to alleviate the stress?

SR: We need to be as innovative as we can to maximize wellness, it's hard to say if 20 minutes of going into a respite room will decompress you. With thoughtful design, consider how are you handling the acoustics, how are you alleviating the mental load? From a policy standpoint of getting folks involved, staff retention is a primary fundamental goal of HC institutions. Allow the place where they work to be a place where they feel connected.

JE: We did a recent study on nurse burnout. In the first hierarchy, we asked how we as leaders can be more responsive. Nursing is a team sport, yes, you are assigned your 3,4, or 5 patients, but we are constantly communicating, watching everything. It's important to see across the unit so we can do a better job of supporting the nurses.

SR: Showing them that their input makes a real difference, shadowing, looking for workarounds, not seeing them as a negative. Instead of looking at it as something to be eliminated, I use it as a source of innovation. I used to think of it as a big grandiose idea but now I see if we make a positive change and do that every day, in a year, you have a 37% positive improvement.

JE: A small design element can move the needle. With a nurse who Is dispensing complicated meds, put red tape down as sign, "Do not to interrupt." That red tape becomes a signal, do not interrupt. It's pretty minor but once you see it across shifts and compound it, you can have such a tremendous effect.

SR: It is hard to step away and say I'm going to the respite room, if your stress is at 90 percent, it's not going to alleviate the burnout. Yes, continue to design, but look at micro moments, where anxiety runs the highest. The work front line providers do is highly stressful. Can we use natural light to bring anxiety down?

Moderator Debbie Gregory: *QUESTION: What advice would you give?*

KN: In building relationships, I end up becoming the connection between the staff and the design team. Everyone has their wants and needs. I am the connection; I bring back the essence of everything the nurses tell me to design team. These are the things they need in the room. When we built our trauma bays, I brought a trauma manager in to consult, get their team ideas and bring them back. We talk through how this looks before they get it on paper.

DG: *QUESTION: Jennie, you've had quite a few successful practices, what are design moments that integrate well?*

JE: My favorite project, with incredible outcome, used lean processing on an IPD project. Everyone was aligned with desired goals at Akron Children's in new Nicu, with new ancillary services. They understood the power of the clinical voice. There were no silos. The evidence-based processes were adhered to. We considered who the decision makers were and what the process was going to be. Through strategy, pediatric sessions, they did intense value screen mapping, ED, ICU, what they discovered in the outpatient advisory session, they called it the Circle of Doom.

We had large scale department meetings, also I think the other thing was clear metrics were established, we all knew where we were moving towards. They involved an organizational development expert. That person connected with the clinicians. Intense change engagement process. The book, The Influencer. The result was 50 days cut off of construction saving $40M, staff and family satisfaction achieved. The integration – no silos, everyone aligned, from top to bottom.

DG: Leadership within the units creates the change. One thing we don't do is have the onboarding of everyone at the same time. That's one way I think and hope that integrating clinicians will evolve to – onboarding all together. *QUESTION: What's one piece of advice to offer to better integrate?*

SR: Do due diligence early on. It's clinical co-design and shadowing, really showing you are authentic and trying to understand their realities. Use those as sources for innovation to move the industry forward. In HC, we are working toward improving access. We have pronounced staff burnout. Use power of design for staff endurance, to create spaces for the people who are delivering the care.

KN: Involving the staff, we've been lucky with ours, if something is not working, we all go together.

JE: The Chief Nursing officer is responsible for 80 percent of staff and responsible for patient outcomes, she drives the why. Evidence-based design is important. They have a requirement to involve clinicians. Ask for the organization chart. Who reports to who?

KN: We are going from 22 bed to 47 bed facility, actively in the ED, my team is amazing, I see them every day, we have that connection where we talk all the time.

Why Build Shell Space in Healthcare Facilities

Moderator: *Ashley Dias, AIA, Health Practice Leader, Principal, Perkins&Will*
Panelists:
Christopher Cortes, Manager Facilities Planning & Design, MD Anderson
Soudabeh Eskandari, M.Arch, EMBA, LEED AP, Director, Construction Ops, Harris Health
Skanda Skandaverl, Division Director, Facilities Management, Energy, and Infrastructure, CommonSpirit

Moderator Ashley Dias: *QUESTION: What master planning is necessary with shell space?*

CC: For any successful institution, it's having a clear well-defined vision for what your facility will be like, what floors will be high tech, what is the future growth, what programs will need more space? What is your expected growth in that area? We recommend having all that documented so you can protect that space. You don't want to set up for a clinic and later realize you need MRIs up here.

SE: Shell space option is a good strategy. Definitely it speeds up future construction, you don't have to go through extra permitting. Healthcare is growing so fast, it's wise to have shell space.

She showed slides of the planned $2.5B, 1.3M SF new John O'Quinn Hospital with helipad, Level Trauma, parking for 1200 cars, 450 beds, 120 Shelled, 330 Licensed Beds Day 1, ante post 30 beds, NCU, 30 beds, 12 Labor/delivery beds on Level 5. There's a savings with shelling for additional identified patient rooms and ORs, savings of $49,522,402 including $28,144,118 on construction. Level 2 is cafeteria, conference center, All Faiths Chapel, care management, observation (48 beds, not licensed), Dialysis (16 beds) support spaces and offices. In addition to the $40M commitment from the John O'Quinn Foundation, $2.5 billion of the total funds were approved by voters in 2023 to go toward Harris Health System's broader strategic facility projects. Opening is scheduled for 2029. The hospital is the flagship project of Harris Health's $3.2 billion strategic plan to modernize care across the county, and it's an expansion to the old LBJ facility built in 1989 at 5656 Kelley.

CC: When you see other needs that weren't anticipated in master plan, you may have to pivot, what will you need from your team. Maybe it's being used for storage space that can be easily dismantled.

SS: Not all Shell Space is the same, where's the juice worth the squeeze. Across the street we have a lot of shell space, where construction goes on starting 630 a.m., so you cannot be drilling, jack hammering when patients are sleeping. It's not healthy.

He cited an example where a main breaker had been tripped and he had to drive in from Spring, so there have to be planned safeguards. Its' critical you have a master plan; it's changed hands so original plans must be revisited. Some shell space is used for construction storage and as a

staging area during activation, but we need to consider compliance with fire and life-safety requirements. Also consider security and access control.

SE: Lessons learned to reduce noise and minimize patient disruption during construction. Soudabeh used an example of connecting the skybridge to Labor and Delivery department (active hospital). She also listed these thoughtful strategies:

- Transparency and leader involvement from the earliest planning stage (6 months in advance) by having meetings.
- Conducting detailed infection control risk assessments.
- Scheduling disruptive work during low-volume periods whenever possible. (reviewing the baby delivery data for last 10 years and the best month was the month of February)
- Establishing clear communication protocols with staff and physicians by having a monthly then biweekly meetings as we got closer to the construction date.
- Implementing noise, vibration simulation 3 months in advance, and monitoring the noise level to make sure it meets the healthcare standards.
- Work around patient/clinical team schedule and be ready to shutdown at any moment they ask to.

AD: *QUESTION: What is the longest time the shell space sat empty? Ashley saw one that was not built out for 20 years, the codes had all changed. What do you do when things don't go according to plan?*

CC: Shell Space almost doesn't exist, if someone even looks like they might move out, we get phone calls, hey can I have it? There's always something that can be done, create new programs, use it for education, there's almost nothing that can't go in.

One story, we had shell space that sat for several years, we went up to take a look at it, nobody had checked on it, the maintenance guys had built a kingdom up there. Unknowingly, it became enabling project in unprogrammed space.

SE: We had a similar space where we found a little teddy bear, inhabited by a homeless person.

Extending & Protecting the Life of Capital Assets, Strategies for Economic and Weather Volatility

Moderator: *Jana Summey, MBA, ASSE 12080, Health Care Sector Lead, Diagnostics Group, Walter P Moore*
Panelists:
Julie Lucas, MS, Vice President, Facilities Operations and Auxiliary Enterprises, UTHealth Houston
Rucker Simon, PE, Principal, Walter P Moore
Tarek Thomas, Associate Vice President, University of Texas Medical Branch
Mark Williams, PhD, PE, SE, Managing Principal, Managing Director Diagnostics Group, Walter P Moore

Tarek Thomas:

At UTMB, Ike kicked our teeth in, they almost shut down UTMB, a lot of legislators thought what are we doing having a medical center where you have storm surge. Ike was a Cat 2, and we got surge of 3 or 4, it shut down campus for 3-4 months, we had to go through a complete reset, moving forward. UTMB opened in 1891 as the nation's first public medical school and hospital under unified leadership—so already we're already pioneered. What began as one hospital and medical school building in Galveston is now a major academic health sciences center of global influence; a world-renowned research enterprise; and a growing, comprehensive health system with four hospitals, providing 46,000 jobs. UTMB has a $4.9B annual statewide economic impact, in terms of business volume, personal income and durable goods purchases.

Since UTMB was founded, we've overcome climate change. rising floods and freezes, it actually froze in Galveston, so what we had to do is to become proactive. We had been reactive, putting band aids on fixes but Ike forced us to rethink how we think about our asset management. We moved everything to second floors and built with materials where we could mop it out.

FEMA requires you to be above 13 feet, we built it to 25 feet. We use TECO, the organization that provides thermal utilities to the entire TMC in Houston and we have three plants. We built a 25 ft.-flood wall around entire plant, and also built an East plant, 30 feet up in the air. It goes beyond just rebuilding campus – we use .316 stainless steel, and it needs to be coated with epoxy, to withstand environmental conditions. We learned you need to make that up front investment.

Rucker Simon:

Tools are probabilistic. What we see is that the once rarer storms are now happening more frequently. We look at historical data, now with Atlas 15 data sets, which apply temperature metrics so we can identify increasing rainfall volumes by temperature scenario. We build out models that account for this rainfall so we can maintain resilience. It's not just future

proof; it's future proof on a worst-case scenario. This gives us the best chance of success in the face of a changing climate.

Julie Lucas:

We look at whether it is an older building or is it a new build? We have a 500 ft. flood wall, flood gates, and interior flood walls around MRIs at UT Health Science. We are now more cautious about what we put in basement. In the past, we had vivarians in basement but not now. Those are the areas where we are moving forward.

TT: With the curtain wall, if we have windstorm, we're not going to meet the minimum. We built a pressure chamber to simulate a Cat 4 Hurricane. We want that hospital to be a safe haven. You do not want to evacuate a hospital so. After an event, the hospital is where everyone goes. People from Beaumont come to UTMB. They aren't able to make it to Houston.

Each speaker hit on areas of capital asset management and capital constraints vs. more long-term planning.

QUESTION: Julie asked how many in the audience were owners, how many have perfect deferred maintenance backlog? How do we sell that to leaders?

JL: We say this is our best practice. We need to check out the structure; make sure we get the money to actually maintain our buildings. These are all things that are very sensitive to impacts.

TT: It's a pull- and-tug with our leadership, we need to look at total life cycle cost, we all know net present value money, when it comes to existing facilities. The School of Medicine building was built in 1890s, a lot of our leadership doesn't think about something breaking. In past, they'd run equipment until it failed, every week there was a crisis. Now we have new leadership that understands deferred maintenance and how it translates to lost dollars. Then they'll start giving you a little money. In retro-commissioning buildings, they see their bottom line, they can go buy new shiny things. We're looking at its preventive maintenance software to assess and pinpoint failing equipment. We're identifying areas that need to be replaced so it won't wreak havoc on our systems.

Mark Williams:

Key word is proactive. It's usually Fix on Failure, which is not best.

QUESTION: What does capital asset management mean to you?

MW: Moving Beyond "Fix on Failure": To me, capital asset management is about shifting from a reactive "break-fix" cycle to a predictive, data-driven lifecycle.

The Life-Cycle Lens: It means looking at a building not as a static object, but as a series of depreciating assets that require "preventative maintenance" at the capital level, not just the operational level. It's about ensuring that when we spend a dollar today, it saves us five dollars in emergency repairs ten years from now.

In considering how technology can aid in better planning to weather the storm, Williams uses three major tools.

1. Digital Twins as a "Crystal Ball": We use digital twins to simulate how a building will perform under stress (e.g., a 100-year flood or a major thermal event).
2. Continuous Monitoring: By integrating IoT sensors with our Building Automation Systems (BAS), we can detect "micro-failures"—like a pump vibrating slightly off-center—long before it results in a system shutdown. Technology allows us to see the "health" of the building in real-time.
3. The Data Foundation: A Computerized Maintenance Management System (CMMS) is only as good as the data entered into it. If we aren't tracking "Mean Time Between Failures" (MTBF), we're flying blind.

QUESTION: Planning vs. Maintenance: What should be on your checklist?

4. The "Hidden Systems" Audit: Williams' checklist always includes "hidden" infrastructure: façade anchor integrity, underground utility mapping, and basement waterproofing.
5. The Review Cycle: Williams advises a review of the Capital Expenditure (CapEx) plan against our Facility Condition Index (FCI) every 12 months. If the FCI (a measure of a building's physical condition) is rising, our capital plan is failing to keep up with the building's age.

JL: One of the things we did wrong is we don't bring maintenance team in during design. They need to be at the table. This area has a lot of room for growth. Once we have turnover of the facility, what lessons did we learn? Do we have access where we need access for maintenance team? Can we marry the maintenance team and design?

RS: Maintain your storm sewers and integrate landscaping on the exterior of buildings. There's a wide network of storm sewers with massive underground detention systems. If they get clogged up, they get full of debris, mud, so they need to be consistently maintained and potentially cleared out. Consider everything around the building in addition to the building itself.

TT: Bring the maintenance team along for the ride. One example is where they saved a Niagara Falls situation because they knew immediately where the shut off valve was.

QUESTION: How do you see resilience technology impact the way we plan for better resiliency?

JL: We mentioned AI, is playing a lot into being predictive, plotting out areas where we start seeing failure, also water sensors we are putting throughout buildings, cameras in different areas, putting electronic tech in buildings,

RS: In monitoring water flows, resilience is inextricable from sustainability. When you monitor flows to check for leaks, you catch them early and in smaller amounts and reduce your demand on potable water supply. You also see resilience with more weather-smart storm management technology, like batch-detention systems that can store water for reuse, empty

themselves before rainfall events, and then capture and store that rainfall when it happens. Weather integrated technologies also give us real time predictive capabilities that can help protect our assets. There's a flood alert system for TMC - using real time flood gauge data and Doppler rainfall estimates, it predicts peak flows and notifies when it's time to close your floodgates.

TT: We look to our engineers in how we design replacement of our assets, we are replacing air handling units, we'd like to move them up to 2nd floor but there was no easy way to do it. The one on first floor is 100 percent stainless steel, when we flood it automatically gets shut off and the manifold continues to work, so ac never shuts off. We're asking engineers to bring that to us. Now we're having problems with elevators in the hospital, so we're getting the notification in place so people can respond quickly. We have flood walls to protect our elevators. Make sure your structural engineer looks at basement. Water can come in and create a boat. We are implementing hard materials that are non-porous, tile-protected surfaces to avoid times like during Ike our entire concourse was flooded out, and we needed to have public front of house access.

JL: We have flood gates and terrazzo flooring on first floor, with a little gap before floor with drywall. Classrooms, not critical spaces are on the first floor.

Making Old Healthcare Facilities New Again

Moderator: *Raul Benitez, PE, Director of Engineering Innovation, PBS Engineers*
Panelists:
Mark Denham, MS, LCC, CHPA, Regional Security Director, Memorial Hermann; Adjunct Professor, SHSU
Eric Jacob, Healthcare/Life Sciences Manager, HID Global
Thomas Newsom AIA, CDT, LEED AP, Managing Principal, E4H/MOREgroup
Christy Rivas, Senior Facilities Space Planner, Texas Children's Hospital
Mark Stewart, AIA, Project Director, SCP ACS Bond, Harris Health

Mark Stewart:

We really want to investigate as best you can, we have the triads, making sure we are in alignment, renovation work is very challenging, if we were aware that the future flooring needed to be replaced, we'd include that in our original scope of work. Keeping all the end users informed. Christy Rivas, I come from a place of positivity, teamwork and collaboration. I think establishing a foundation for that – creating the cadence of the meeting, always on a positive note, tied to things that make us human, helps us create bond, the mission, remind people of what the mission is,

Mark Denham:

At MH, with security = having the right technology is top of mind and I help focus on making campus safer. If we don't make right decisions up front then we can't do our job.

Eric Jacob:

Cards are vulnerable, also in gaining understanding the IT structure, educate where the money needs to be.

Moderator Raul Benitez: *QUESTION: We have owners and consultants. How do we meet for ultimate outcome to bridge the gap?*

Christy Rivas:

I deal with this often as a space planner, the better I know how you operate, when we partner with engineers, the better it will go. We're creating a program for a new facility, the architects left out one of the programs, it has to be respected from both ends. There has to be a partnership.

MS: In working in Nicu, to avoid infant abduction, we had a new standard we wanted to deploy in an older system. We use cameras, from day one.

RB: *QUESTION: With access control, smart systems – what is the system that gets neglected the most?*

EJ: In a brand-new building, had surgery, a nurse noticed she had 10 IDs for her badge, all the buildings don't have same level of technology. Older buildings don't want to put in new readers, even in parking garage, they were skipping that part. Duplicators can wreak havoc. Its not different than fraud. It's cyber security. Access control.

MD: It's duress alarms, active shooter mitigation, workplace violence, all these pieces should communicate together, like an ecosystem.

MS: To me it's the unknown, we think we know what is in an area, but there is fear of the unknown, having proper controls in place, to make sure the assemblies are there. Address it at that point, build in enough contingencies.

RB: *QUESTION: How should owners prioritize renovations when budgets are limited?*

MD: It's a risk mitigation exercise, what allows patients to have best healing experience and what continues continuity of operations? Balance low probability and high consequences. With an active shooter, healthcare is one of lowest areas where it occurs, but if we don't train or have proper infrastructure, the consequences are extremely high. We look at the ifs - If we had canine dogs who are trained to detect weapons, if we had metal detectors, tools to use as a force multiplier.

MS: I believe great healthcare design starts with great healthcare planning. It has to be properly documented. You have to have the right team to execute it.

Thomas Newsom:

We have the luxury of having sophisticated owners, they are talented, when you get all the voices in the room to be able to vet the plan, and integrate input from clinical staff during construction. It's important to have a holistic plan from beginning to end.

RB: *QUESTION: What are common mistakes in renovation?*

TN: Scope definition by far.

IFHE-International Healthcare Facilities, AMFP is exclusive host partner, with partners from all over the world

Glenn Fischer shared this is like the Olympics, we bid on it. We are the host organization and host country. We partnered with Emerald X; we are collaborating with both events in New Orleans. We are raising awareness of this event. Please help us with promotion of this event to your professional networks. It's the biggest undertaking in our history. Questions, email

Glenn Fischer: gfischer@squarefootage.net

Jonni Johnson JJohnson@rockitstrategy.com

Registration is officially open for both the International Federation of Healthcare Engineering (IFHE) 29th World Congress and the 2026 Healthcare Design Conference + Expo, co-locating together Oct. 17-20 in New Orleans. This co-location event delivers an unprecedented global experience that brings together the full spectrum of healthcare design, engineering, real estate, planning, construction, and operations professionals.

To experience the full programming for both events, register for an HCD + IFHE combo badge that provides access to ALL conference sessions. *(Attendees may not access the other event's conference sessions without purchasing the HCD + IFHE combo badge. The expo hall is open to attendees of any badge type.)*

The Tricks of the Trade & Traps to Avoid - Camfil, Cade Blackwell

Lunch provided by Mohawk Group, Ellen Zucker and Laurie Bricker

Mohawk Healthcare's Ellen Zucker, Senior Director National Accounts | Healthcare and Laurie Baker, Account Executive, hosted lunch. We are the largest flooring manufacturer in the world; our mission is to create products that are better for people and the planet. So many of you have our products installed in your facility and we're happy to sponsor lunch.