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EXECUTIVE DESIGN GUIDE | SEPTEMBER 2026

THE SMART HOSPITAL DESIGN GUIDE

DESIGN THE WORK BEFORE YOU SCALE THE TECHNOLOGY.

A practical toolkit for moving from an isolated virtual care use case to a reusable enterprise capability.

SMART ROOM	SMART HOSPITAL	SMART FLOW
the endpoint	the operating model	the value

This guide is the how-to companion to *From Smart Rooms to Smart Flow*. It does not re-argue the case for virtual care. It gives leadership teams a sequence of decisions and worksheets to design the first use case well enough to scale.

Six design decisions, in sequence

Use the step number as a table of contents. Start with the tool you need, but do not skip the operating model decisions before go-live.

01
MAP
Where does the patient journey stop or slow?

02
PRIORITIZE
Which problem is high impact and feasible to change?

03
OPERATE
Who does what differently once virtual care is available?

04
CONNECT
Can the infrastructure support multiple workflows?

05
ADOPT
How will frontline teams shape and trust the model?

06
MEASURE
What will prove value and trigger the next scale decision?

CORRESPONDS TO WHITE PAPER RULE 1 : DIAGNOSE THE CONSTRAINT

Find where the patient waits

Map the entire patient journey before assigning a virtual solution. The objective is to name the exact point where a person, decision, handoff, or expertise gap is slowing flow.

WORKSHEET | MAP YOUR OWN PATIENT JOURNEY

STAGE	WHERE DOES WORK STOP?	WHO OR WHAT IS MISSING?	VIRTUAL LEVER TO TEST
Admit / Transfer			
ED			
Consult / Decision			
ICU / Med-Surg			
Discharge / Home			

USE THESE PROMPTS

- Where is the longest wait after a clinical decision has already been made?
- Which delays are caused by missing expertise rather than missing physical space?
- Which work consumes bedside time but does not require the bedside clinician?

> **“Smart flow is really relieving bottlenecks throughout the entirety of the hospital, whether that be in the ICU, the floors, or the emergency department. What we're trying to do is create seamless patient flow throughout the entire system.”**
>
> MARIO V. FUSARO, MD, MS | EQUUM MEDICAL

CORRESPONDS TO WHITE PAPER RULES 1 AND 2 : DIAGNOSE THE CONSTRAINT, MOVE EXPERTISE

Start with a high impact problem the organization can actually change

The right first use case is the problem with enough value to matter and a manageable implementation lift. Rank locally, not from a generic feature list.

WORKSHEET | IMPACT VS. LIFT

HIGH IMPACT / LOWER LIFT **START / PROVE**	HIGH IMPACT / HIGHER LIFT **BUILD / SCALE**
LOWER IMPACT / LOWER LIFT **STANDARDIZE**	LOWER IMPACT / HIGHER LIFT **QUESTION**

SCORE EACH CANDIDATE USE CASE

CRITERION	QUESTION	1-5	NOTES
Clinical / safety value	Does it reduce harm or improve access to needed expertise?		
Flow impact	Can it change disposition, LOS, discharge timing, or transfer?		
Workforce impact	Can it return time, extend scarce expertise, or stabilize coverage?		
Technical readiness	Can current endpoints, EHR, network, and identity support it?		
Change readiness	Is there an executive sponsor, clinical owner, and frontline champion?		
Measurement readiness	Can baseline and post-launch outcomes be captured?		

> **“Find the combination of lower lift, high-impact problem, so that you can really demonstrate success, and then build your program from there.”**
>
> STEPHANIE LAHR, MD, CHCIO, FACHDM | VITAL THREAD ADVISORY

CORRESPONDS TO WHITE PAPER RULE 4 : DESIGN THE OPERATING MODEL BEFORE SCALE

Define the clinical operating model

Before go-live, document the work in enough detail that a bedside clinician, virtual clinician, and operational leader would describe the same workflow. If a field is unanswered, that is the gap to close before launch.

WORKSHEET | USE-CASE DESIGN CANVAS

DESIGN FIELD	DECISION TO MAKE	YOUR ANSWER
Problem and cohort	Which patients, units, time windows, or conditions are in scope?	
Trigger	What starts the virtual interaction?	
Virtual role	Who responds, with what credentials and defined scope?	
Bedside role	What remains with the bedside team, and what is intentionally removed?	
Information	What EHR, imaging, monitoring, medication, or contextual data are required?	
Decision authority	What can the virtual clinician decide, recommend, order, or escalate?	
Escalation and downtime	What happens when the patient deteriorates, a clinician is unavailable, or technology fails?	
Documentation and handoff	Where is the encounter recorded, and how is the next team informed?	
Success	Which three to five measures define a successful pilot and scale decision?	

> **“We're not replacing any of our bedside personnel, we're just taking some of that burden off of expecting them to be all-knowing, all-seeing, at every point in their day … How can we share that responsibility? So we went through a checklist of: who are we going to monitor? What are we monitoring? What's the tech that's going to support us in that?”**
>
> LESLIE FERRELL, MHA | HARRIS HEALTH

CORRESPONDS TO WHITE PAPER RULE 3 : CENTRALIZE WHAT BENEFITS FROM SHARED OVERSIGHT

Test the architecture for reuse

The conceptual five-layer architecture belongs in the companion white paper. Here, test whether your current environment can support the next workflow without another disconnected deployment.

CHECKLIST | ARCHITECTURE TESTS

TEST	QUESTION	YES	NO	GAP
Workflow reuse	Can the same room endpoint support observation, nursing, physician, and specialty workflows?	☐	☐	
Clinical routing	Can the platform direct the right request to the right virtual role without manual workarounds?	☐	☐	
Context	Can the remote team see the clinical data needed to act, not just the video feed?	☐	☐	
Interoperability	Can encounters launch and document inside normal EHR and communication workflows?	☐	☐	
Resilience	Are downtime, privacy, cybersecurity, and device-management processes enterprise-grade?	☐	☐	
Data	Can adoption, response time, flow, safety, and outcome measures be captured without manual reconstruction?	☐	☐	

ARCHITECTURE DESIGN RULE

One endpoint should be able to support more than one human workflow, and should not prevent future computer vision, ambient listening, or AI-enabled monitoring from using the same room infrastructure.

> **“The technology in the room matters. It's the capability that that technology creates without being an imposition to our patients.”**
>
> LESLIE FERRELL, MHA | HARRIS HEALTH

Make the workflow usable, then measure whether it changed care

05 ADOPT

Treat implementation as care transformation.

- ☐ Frontline co-design
- ☐ Role clarity
- ☐ Clinical champions
- ☐ Communication around the problem being solved
- ☐ Patient privacy, language, literacy, disability, and human handoff

RULE TAG: WHITE PAPER RULE 4

06 MEASURE

Use a balanced scorecard. Choose one to two leading indicators and one to two outcome measures in the domains relevant to the use case.

Access	Safety / quality
Flow	Experience
Workforce	Economics

RULE TAG: WHITE PAPER RULE 5

WORKSHEET | YOUR BALANCED SCORECARD

DOMAIN	LEADING INDICATOR	OUTCOME MEASURE
Access		
Flow		
Workforce		
Safety / quality		
Experience		
Economics		

> “It can't sit in an innovation bucket; it really has to be this concept of care transformation.”
>
> STEPHANIE LAHR, MD, CHCIO, FACHDM | VITAL THREAD ADVISORY

MOVE FROM INTEREST TO AN EXECUTABLE OPERATING PLAN

Compress the six decisions into a fixed timeline with accountability

The sprint is not a separate project plan. It is the six-step framework in sequence: Diagnose (Map and Prioritize), Design (Operate and Connect), and Ready to Launch (Adopt and Measure).

DAYS 0-30
DIAGNOSE

- [ ] Executive sponsor and clinical owner named
- [ ] Patient-journey bottleneck mapped
- [ ] Baseline measures collected
- [ ] Existing endpoints and programs inventoried
- [ ] Target cohort and workflow selected

DAYS 31-60
DESIGN

- [ ] Virtual and bedside roles defined
- [ ] Trigger, routing, and escalation mapped
- [ ] EHR, device, network, and security needs confirmed
- [ ] Frontline workflow validation completed
- [ ] Success measures and thresholds agreed

DAYS 61-90
READY TO LAUNCH

- [ ] Training and communication plan complete
- [ ] Operational coverage and scheduling confirmed
- [ ] Downtime and support model tested
- [ ] Dashboard and measurement approach ready
- [ ] 30, 60, and 90 day review cadence scheduled

FIVE TACTICAL QUESTIONS BEFORE YOU INVEST

1. What exact patient or workflow cohort is in scope?
2. Who owns the patient before, during, and after the virtual interaction?
3. What work is removed from the bedside rather than duplicated?
4. Can current infrastructure support the workflow without a new point solution?
5. What result will trigger scale, redesign, or stop?

> **"I think that smart hospital investment is the most important thing we need to do for our future. But we have to survive today."**
>
> LISBETH VOTRUBA, MSN, RN, FAONL, CAVRN | AVASURE

Design the work before you scale the technology

The smart room is the endpoint. The smart hospital is the operating model. Smart flow is the value.

READ

Companion white paper

From Smart Rooms to Smart Flow

TALK

Start a design conversation

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Evidence and study limitations are detailed in the companion executive white paper. This guide is a practical planning tool, not clinical or financial guidance.