

Building a Center of Excellence

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HOSPITAL
For Women & Babies



Key Components

Visualize/Define

Validate

Design/Build

Accreditation



Evolution of Surgical Techniques

Open Surgery

1. Widely Accepted
2. Increased risk of complications
3. Longer recovery

Minimally Invasive Surgery

1. Growing over 30 years
2. Longer learning curve
3. Shorter recovery
4. Less complications

Robotic Surgery

1. Increased the application of MIS
2. Increases surgeons longevity
3. Numbers of cases and types of applications of Robotic MIS increasing exponentially globally

What is a Center of Excellence?

Specialized programs within healthcare institutions which supply exceptionally high concentrations of expertise and related resources centered on particular medical areas and delivered in a comprehensive, interdisciplinary fashion—afford many advantages for healthcare providers and the populations they serve.*



What are the challenges?

Healthcare providers have many opportunities and challenges to serve their communities:

Financial Resources

(limited)

Competition

Technologies

*(expensive/
expanding)*

Oversight Bodies

*(demanding ever-
increasing
accountability)*

Patients are more informed

*(in search of best care
available)*

Why build a Center of Excellence?

Distinguishes institutions as citadels of expertise

- Increasing opportunities to attract patients

Enhances quality through the application of innovative tools, technologies, and techniques.

- Improve outcomes

Recruitment

- Increase the reservoirs of skill and experience on clinical and administrative fronts.

Financial benefit

- Increasing efficiencies
- Improving reimbursements



What's required to build a COE?

- The acquisition of a detailed understanding of the delivery model and its benefits.
- Concerted actions must be taken on a particular series of administrative and clinical fronts, treating them in prescribed manners to afford synergies which yield an exceptionally high level of care.



Is it really worth it?

- They have the ability to dramatically enhance the depth and breadth of healthcare services available in communities.
- More than a marketing ploy
- Root value rests less in their promotional potential and more in their ability to deliver enhanced healthcare experiences



Why share with you how to build one?

Issues

- Financial
- Competition
- Keeping “trade secrets”

Need

- Comprehensive assembly guidance
- Done mostly through trial-and-error
 - Diminishes the potential for success
 - Reduces healthcare opportunities available in their communities



What are the key components to building a COE?

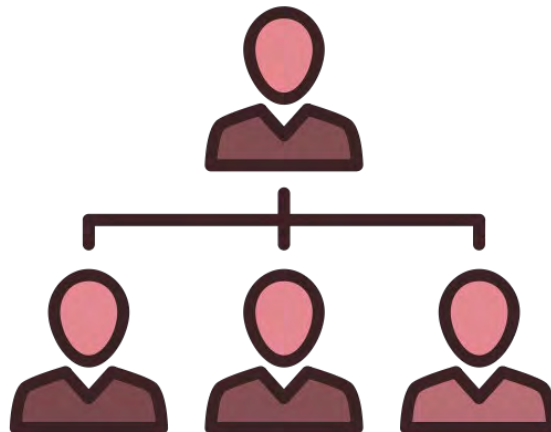


Organizational Design

How are work resources and responsibilities shared?

Shared governance systems

- Characterized by transparency
- Fosters collaboration across disciplinary lines and ensure joint accountability for outcomes



Servicescape Design

Customizing entire servicescapes to serve patients experiencing the particular medical conditions addressed by the given centers

Personnel

Architecture

Parking

Signage

Webpages

Equipment

Technology

Ergonomics

Medical Care

To provide a level of medical care that's difficult to match outside of the center of excellence delivery model.

- Designed to support patients from their initial presentation through to completion of service delivery.
- Medical care isn't delivered in assembly line fashion but instead is customized to address the specific wants and needs of individuals you are targeting



Marketing

Proper marketing efforts directed toward promoting the **depth & breadth of services provided, combined with excellent care delivery** which generates positive word-of-mouth communications from patients, centers of excellence effectively **create ongoing top-of-mind awareness** which has the effect of **bolstering patient volume.**

- High-profile status, provide a halo effect which positively impacts all of its service lines



Finances

Derived from the collection of other benefits afforded by these centers:

- Product differentiation improves patient volume
 - Positively impacts bottom line performance
- Quality enhancements attract patients seeking the best care possible
 - Bolsters patient satisfaction
 - Increases positive word-of-mouth communications
 - Reduces the potential for malpractice lawsuits
 - Facilitate the attainment of standards required to maximize reimbursements under models such as value-based purchasing and bundled payments
 - *Additionally, the concerted direction of resources toward highly-specialized areas of care, often centralized at single sites, permits the achievement of economies of scale, further generating savings and improving financial performance.*

Pursuing a culture of excellence

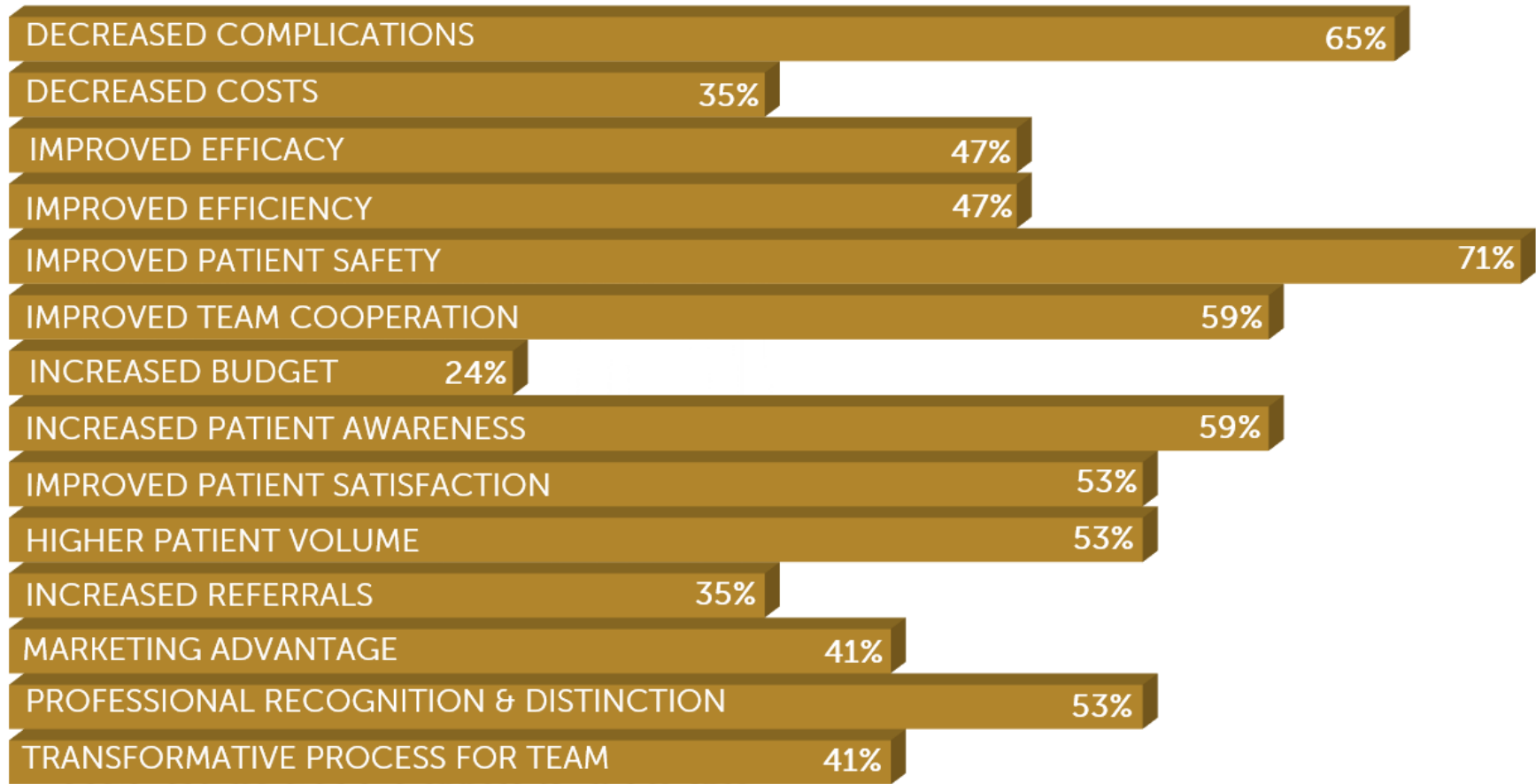


Who is Surgical Review Corporation (SRC)?



- Established in 2003
- Internationally recognized healthcare leader committed to advancing the safety, efficacy and efficiency of surgical care worldwide.
- To achieve its aims, SRC developed a proven methodology known as “Cycle of Excellence™”, involving four interdependent initiatives:
 - Consulting, Accreditation, Education, Data

Benefits of Accreditation with SRC



Benefits of Accreditation

- Transformation process
- Professional recognition and distinction
- Improved safety and efficacy
- Outcomes database
- Decreased costs and complications, improved outcomes and patient satisfaction
- Increased patient awareness and access
- Marketing
- Increased patient volumes and referrals
- Global healthcare and medical tourism
- Network that elevates the specialty



Site Inspections



**Inspectors are
full-time
employees of
SRC**



Consultative



Evaluative

BOLD – Outcomes Monitoring Database

- Essential scorecard measuring the performance of centers and surgeons after accreditation
- World's largest most comprehensive repository of surgical outcomes information
- Real-time access



- BOLD Home
- Summary
- Demographic
- Payor
- History
- Preop Encounter
- Facility Stays
- Post-discharge Encounters
- Patient Forms/Reports

Name: Jones, Tammy | Chart Number: MW11011 | SRC Patient ID: 233221 | Age: 50 | Gender: Female | Race: Hispanic

History

- Hemia surgery history
- Health history

Hernia Surgical History

Previous hernia surgery

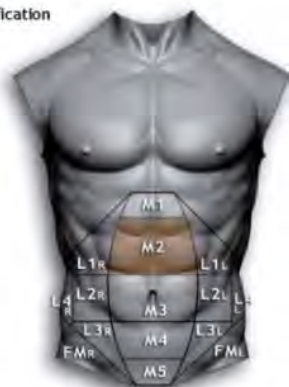
Year	Hernia type	Reason for operation resulting in incisional hernia	Severity	Frequency	Surgical approach	Edit	Remove
2010	Incisional	Trauma	Incarcerated	2-3	Laparoscopic		

Add previous hernia surgery

Did the patient have any previous hernia surgery? Yes No
 Was this a primary or incisional previous hernia surgery? Primary Incisional

Year

Hernia Identification



- Midline**
 - M1-subxyphoidal
 - M2-Epigastric
 - M3-Umbilical
 - M4-Infraumbilical
 - M5-Suprapubic
 - M-Undetermined
- Lateral**
 - L1-Subcostal, left
 - L1-Subcostal, right
 - L1-Subcostal, left, M, right
 - L2-Flank, left
 - L2-Flank, right
 - L3-Inguinal, left
 - L3-Inguinal, right
 - L3-Inguinal, bilateral
 - L4-Lumbar, left
 - L4-Lumbar, right
- Femoral**
 - FM-Femoral, left
 - FM-Femoral, right
 - FM-Femoral, bilateral

Severity
 Incarcerated Strangulated Not incarcerated or strangulated

Surgical approach
 Open Laparoscopic Combined

Surgical mesh
 Was surgical mesh used for this hernia surgery? Yes No
 Was the surgical mesh biologic, synthetic or composite? Biologic Synthetic Composite

Name: , Chart number: mig patient 04172016 1, SRC Patient ID: 563652, Age: 31, Gender: Female, Ethnicity: Asian

Preoperative encounter

Add Visit

PAIN:

Location/Intensity

Additional Information

QUALITY OF LIFE:

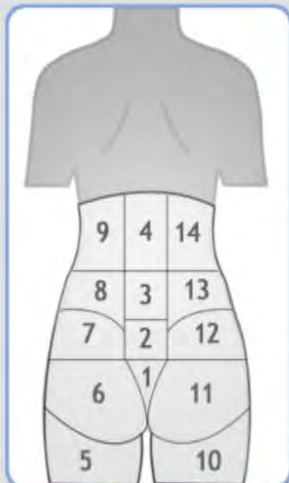
Quality of Life

Pain: Location/Intensity

Identify PRIMARY location and intensity of pain described by the patient:

Genitalia Posterior Anterior

POSTERIOR



- | Intensity | Location |
|----------------------|--|
| <input type="text"/> | <input type="checkbox"/> 1 - Coccyx region |
| <input type="text"/> | <input type="checkbox"/> 2 - Sacrum |
| <input type="text"/> | <input type="checkbox"/> 3 - Lower back |
| <input type="text"/> | <input type="checkbox"/> 4 - Upper back |
| <input type="text"/> | <input checked="" type="checkbox"/> 5 - Left posterior thigh |
| <input type="text"/> | <input type="checkbox"/> 6 - Left buttock |
| <input type="text"/> | <input type="checkbox"/> 7 - Left hip |

- | Intensity | Location |
|----------------------|---|
| <input type="text"/> | <input type="checkbox"/> 8 - Left lower back |
| <input type="text"/> | <input type="checkbox"/> 9 - Left upper back |
| <input type="text"/> | <input type="checkbox"/> 10 - Right posterior thigh |
| <input type="text"/> | <input type="checkbox"/> 11 - Right buttock |
| <input type="text"/> | <input type="checkbox"/> 12 - Right hip |
| <input type="text"/> | <input type="checkbox"/> 13 - Right lower back |
| <input type="text"/> | <input type="checkbox"/> 14 - Right upper back |

Pain intensity slider []



CARE

Communicating Accreditation, Recognizing Excellence

- Used to connect SRC-accredited hospitals and surgeons
- Customer service based program

Increase patient awareness and volumes

Improve patient satisfaction

Create a marketing and brand advantage

Professional recognition and distinction

Increase physician referrals

Sustain a culture of excellence

Accreditation Process

Fees involved

Site inspection

- Takes one week
- Written report

Maintaining accreditation

- Annual inspection
- Remain in good standing
- Site inspection every 3 years



Types of Accreditation

Center of Excellence in Minimally Invasive Surgery (COEMIS)

Center of Excellence in Robotic Surgery (COERS)

Master Surgeon

Multi-specialty

- SRC first credentialing organization offering multispecialty
- Good for showcasing complete surgical program
- Improves quality of care for surgery departments
 - Versus just surgeons or teams within a single surgical specialty

Orlando Health Accreditation



Evolution of our robotics program

Minimally Invasive Surgery

1. 2005 da Vinci Surgical System FDA approved
2. Naysayers in MIS
3. Educating and convincing the surgeon/hospital about incorporating robotic surgery takes a few years

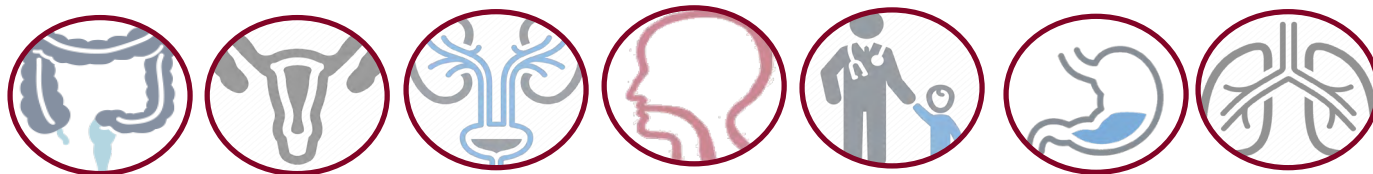
Robotic Surgery Individual Specialties

1. Started with Urology and Gynecology
2. 2010 Colorectal Surgery, Thoracic Surgery and Bariatric Surgery
3. Still working in silos
4. Need to continue to convince organization of benefits

Robotic Surgery Multidisciplinary Program

1. 2015 Paradigm shift
2. Steering committee for robotics program organized
3. Now with 7 surgical specialties that perform robotic procedures and built as a service line

Multi-specialty Program Initiatives





Program Shifts Require Buy In



2015
Program shift



The **BIGGER**
Picture



Metrics



Program Building

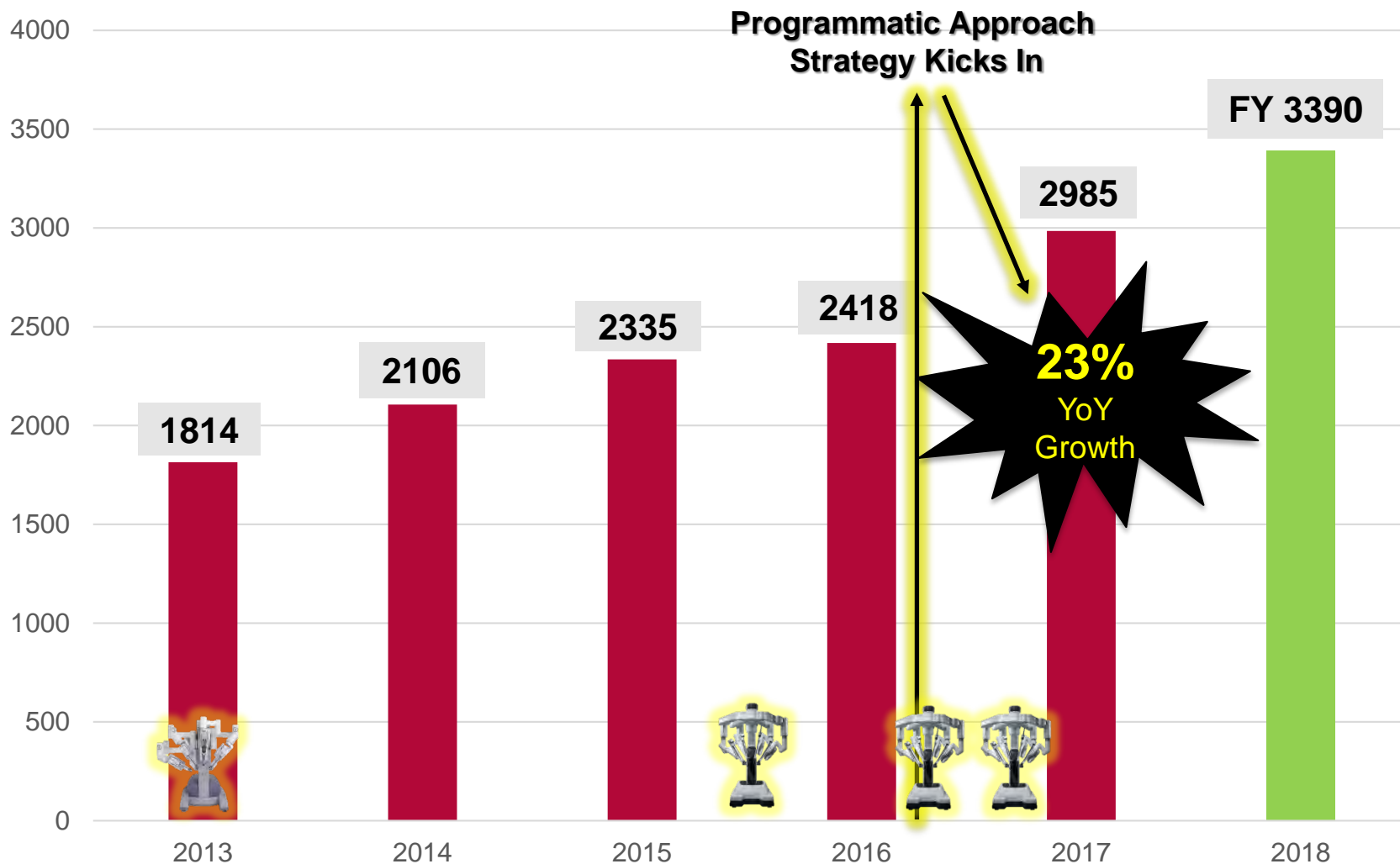


Efficiencies



Economic Value

Orlando Health Robotic Volume



Orlando Health Advanced Robotic Surgery Center

“Virtual” Robotic Center

Launched Sept 14, 2017



Evolution of Centers of Excellence

MIS: COE Multidisciplinary

- Needed to prove we were doing well
- AAGL designated COE
- Need for MIS Program Recognition as an organization
- 2015 SRC awards COE in MIS Gynecology/Gyn Oncology

Robotics: COE Individual Specialties

- Gynecology/Gyn Oncology, Bariatrics, Thoracic has surgeons awarded Epicenter surgeons by Intuitive
- 2016 Bariatrics awarded COE by Surgical Review Board

Robotics: COE Multidisciplinary Program

- 2017 Multiple Surgical Specialties recognized as COE in Robotics and MIS by SRC
- Multiple surgeons recognized as Master Surgeons
- SRC awards Multi-hospital/multi-specialty COE in MIS/Robotics one organization

*“Every **patient** should
have a choice.”*

-Dr. Veronica Schimp
Chief of Gynecologic Oncology