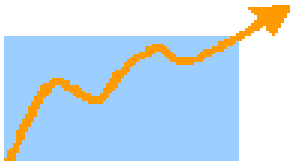


# SpaceMed Trendline

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## Planning a More “Virtual” Center of Excellence



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### Background

For several decades, healthcare organizations have been developing Centers of Excellence (CoE) to better compete for market share, research dollars, philanthropy, and scarce subspecialists in specific programs. Promoting a specific program within the healthcare organization's broader portfolio of services helps to attract the critical mass and resources required to make it successful. Centers of Excellence are commonly developed for cardiac care, cancer treatment, neurosciences, orthopedics, pediatrics, and women's health. Various other clinical programs and specialties may also be candidates for a Center of Excellence.

From a facility planning perspective, decisions to develop specific Centers of Excellence are complicated. Historically, these centers were envisioned as freestanding facilities with the name prominently displayed on the building's facade. Before high-speed Internet/Intranet connections, this concept was promoted to improve collaboration and communication among the healthcare providers as well as to enhance customer service.

### Current Trend

Healthcare organizations are increasingly looking for more cost-effective ways to achieve a similar result while spending fewer capital dollars. To accomplish this, they are focusing on the specific elements that give customers the perception of a “center” to identify which functional components and services will need to be physically adjacent versus virtual and connected electronically.

Unless the center is being constructed as a freestanding facility on a new site, some services could be located within existing space while others are in a new addition. The trade-offs between the cost (initial capital cost and ongoing operational costs) of achieving physical adjacency versus settling for less-than-perfect convenience for the customer need to be reviewed and weighed carefully. The potential for increased revenue, reimbursement, and the demands of donors, partners, or investors may also impact the requirements of the physical design. Unfortunately, physicians often have difficulty imagining a “center” that is not an imposing edifice or at least a freestanding building.

For example, a Heart Center may be developed on an existing hospital campus by creating a dedicated patient entrance that leads directly to the Heart Center reception desk and intake area. An adjacent cardiac resource center for patients and family members may provide educational materials on heart disease and private carrels for viewing videos or accessing computer resources. A contiguous conference room may also be provided for group education on various aspects of heart disease and the lobby may be used for periodic health promotion and assessment activities as well as for fund raising.

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Continued

However, all other Heart Center components may be located within an existing outpatient facility or within the hospital and accessed via an elevator or a short walk down an adjacent corridor — including cardiologist and cardiac surgeon offices, non-invasive cardiac diagnostics, cardiac catheterization lab, cardiac rehabilitation, and other related services.

### Conclusion

From the patients' perspective, once they arrive at a well-identified entrance and are greeted by a friendly and competent receptionist, they are generally oblivious to where they are treated as long as signage is effective and they are not asked to walk a great distance. An elevator ride with a short walk to space in an existing building is not considered a hardship even though the physician leaders may feel that new construction is mandatory.

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