



# Centralized Research Patient Scheduling & Authorizations Clinical Trials Operations

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## BACKGROUND

Patient scheduling is difficult in any medical setting. There is an inherent challenge in coordinating patient care, ensuring alignment with appropriate providers at optimal times. Care coordination is further tested with the addition of the requirements and complexities of a clinical trial. This becomes even harder with strained human resources and limited scheduling capacity. City of Hope's (COH) Briskin Center for Clinical Research (BCCR), which reports to Clinical Research Operations, is an outpatient treatment center focused on providing care for clinical trials patients, that includes research infusion, injections, drug administration, labs, EKGs, evaluation and management visits, and other research related procedures. Over the last 3 years, the BCCR experienced consistent patient visit growth of 18%; however, with limited human resources and clinical trial scheduling complexities, this increase in patient visits caused the BCCR to experience peaks and troughs throughout the day resulting in patient wait delays for infusions, unanticipated gaps between appointments and uneven nursing/patient ratios. To allow for more research patient capacity, maximize scheduling, ensure appropriate staffing ratios, limit delays and manage increased treatment capacity, under the clinical research operations leadership, the BCCR, with the COH Clinical Trials Office (CTO), initiated a multi-prong scheduling pilot program.

## GOALS

- Effective use of the schedule to maximize infusion capacity and limit daily peaks and troughs resulting in:
  - Reduction in patient wait-times;
  - Improvement in nursing ratios and staffing; and
  - No additional staffing resources.
- Identify and train research dedicated scheduling team members, providing them tools to successfully schedule clinical trials patients that:
  - Limited multiple exchanges with care team; and
  - Reduced scheduling related deviations.

## METHODS

- Revised Epic infusion schedule template maximizing patient slots throughout the day with a balanced spread.
- Established a central research scheduling (n=6) and authorizations (n=2) team with direct reporting lines to Clinical Research Operations department.
- Educated the scheduling team on the importance of booking distributions and study windows to best use the available slots.

## OUTCOMES

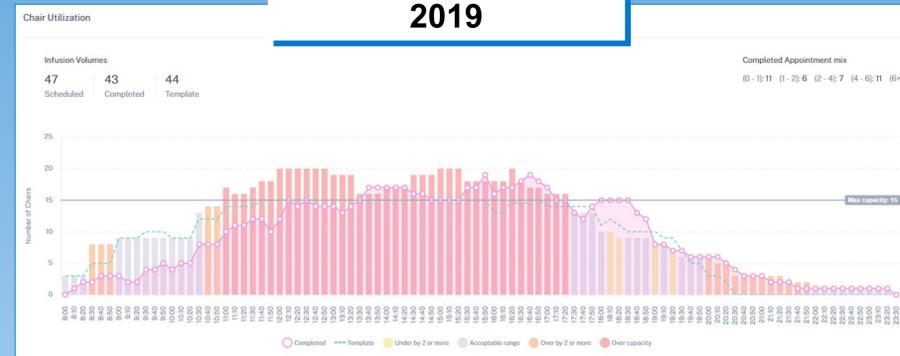
- Reduced the peak to better level load each day by controlling the scheduling availability.
- Decreased average wait time by 27% last year.
- Increased volume without increasing staffing capacity.
- Reduced the number of back and forth exchanges pertaining to scheduling.

(Daily Averages)	AUG - NOV 2017	AUG - NOV 2018	AUG - NOV 2019
Scheduled Patients	32 pts (79 hr)	32 pts (86 hr) +0% (+14%)	38 pts (104 hr) +18% (+32%)
Treated Patients	30 pts (91 hr)	30 pts (103 hr) +0% (+9%)	34 pts (111 hr) +14% (+22%)
Chair Wait Time	57 min (64 min at peak)	33 min (33 min at peak) -42% (-49%)	24 min (25 min at peak) -58% (-61%)

Tuesday, May 28, 2019

Same Day in 2019 vs 2020  
Day after Memorial Day

Tuesday, May 26, 2020



2019

- 47 Scheduled Treatments
- Last Patient scheduled/left: 11:20pm
- Most patients scheduled in unit at one time: 20 (cap 17)
- Times actual was over chair capacity: 2
- Average period wait time: 40min

2020

- 54 Scheduled Treatments (up 14%)
- Last Patient scheduled out 8:20pm (left 11:20pm)
- Most patients scheduled in unit at one time: 18 (cap 17)
- Times actual was over chair capacity: 0
- Average period wait time: 25min (down 15 min/~40%)

## Lessons:

- A recurring process to review schedule availability is essential for safely providing maximal patient schedule slots.
- Improved use of the schedule increased overall patient volume and reduced wait times for patients.
- Direct and centralized oversight of the research scheduling and authorization team better aligns the goals between the CTO and the BCCR with improved overall coordination of care for patients on trial.

## Future Directions:

Moving forward, the CTO and BCCR intends to expand the role of scheduling and authorizations within and improve the tools to give more scheduling autonomy to the schedulers to best manage patients on trial.

## LESSONS & FUTURE PLANS