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Optimizing Infusion Center Utilization: Redirecting Low-Acuity Services to the Clinic Setting

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Learning Objectives

- Explain how to analyze and implement methods for reallocating low-acuity services to alternative care settings.
- Discuss how to foster collaboration between clinic and infusion center leadership to maximize resource utilization, improve staff satisfaction and achieve measurable financial outcomes.

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Capacity Constraints

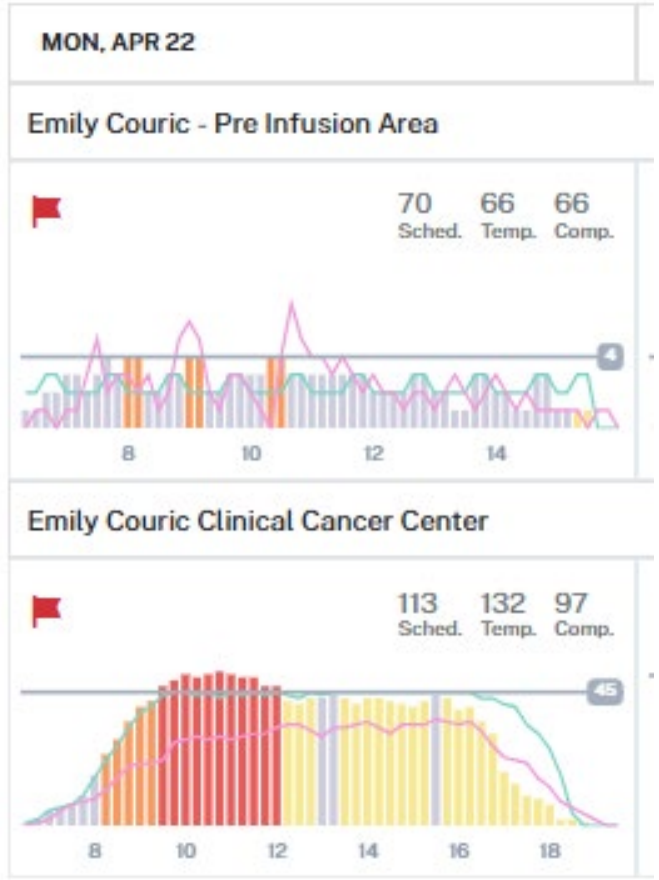
- 679 Inpatient beds
  - 28 dedicated to oncology
  - 15 dedicated to cellular therapies
- Challenges coordinating inpatient admissions
- Large volume of oncology ED boarders
- Decanting into outpatient spaces

Source: UVA Health

Capacity Constraints

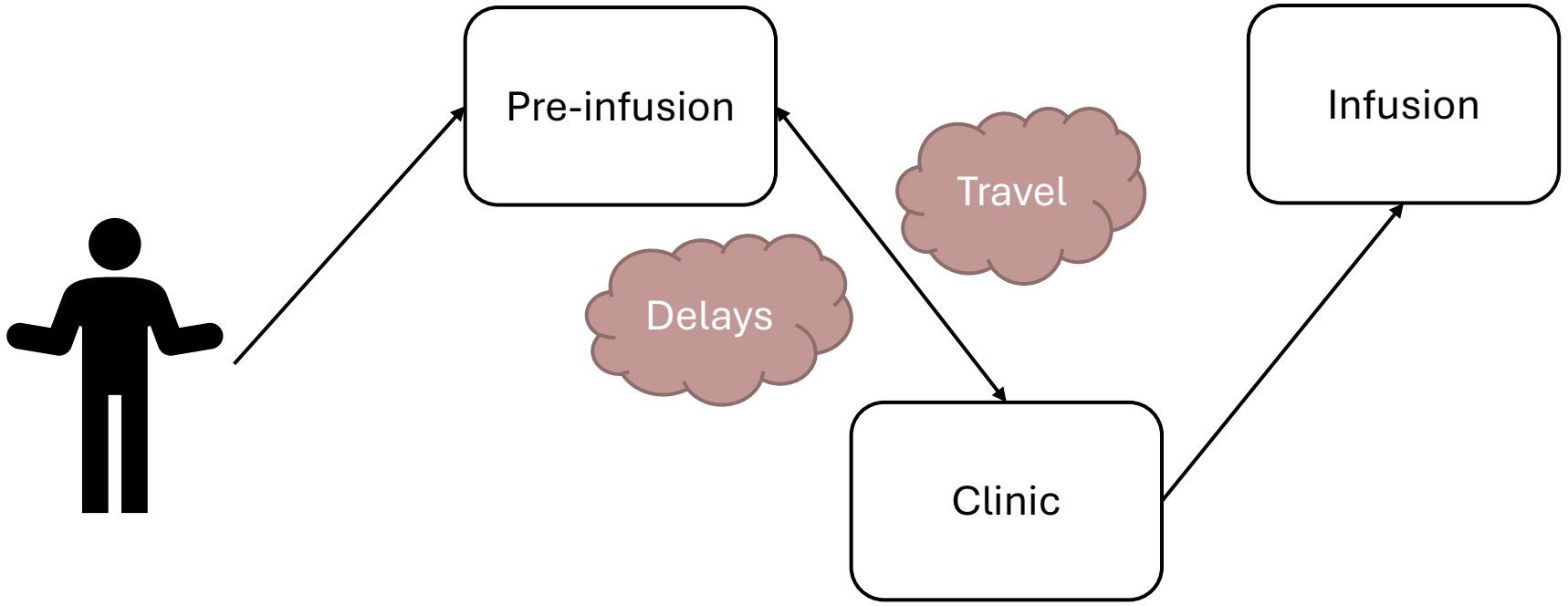
- Patients with central line labs and port access seen in infusion area
- Insufficient space (4 chairs)
- Patient experience: lack of space leads to patients having peripheral labs
- Increased infusion demands, needed additional space for outpatient therapies

Daily Capacity Management



Data source: Daily Capacity Management Dashboard

Patient Throughput Opportunity



Identifying the Solution

Clear Goal:

1. Identify additional capacity without new physical space
2. Optimize the patient experience and flow

Finding the Way:

- Engaged leaders and frontline staff
- Identified underutilized procedure room space
- Smaller center model: complete tasks during the rooming process
  - Found this is not sustainable beyond ~10 exam rooms

Implementation

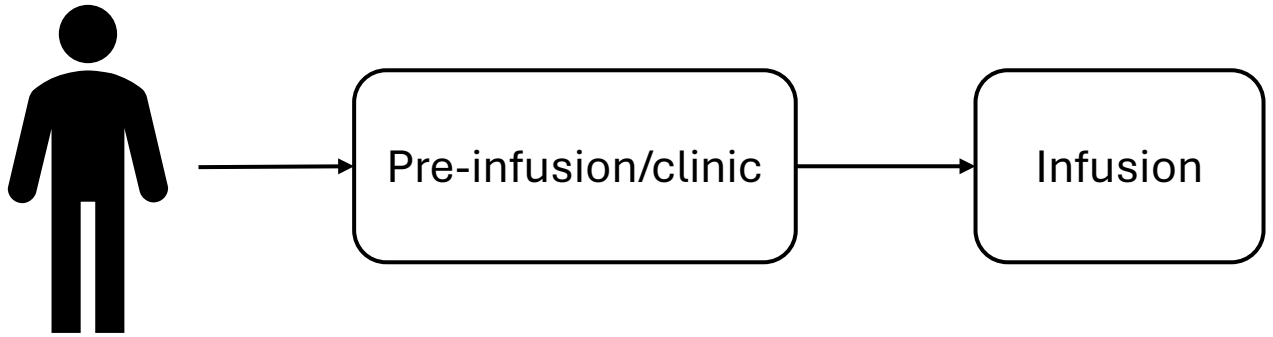
- Minimal refurbishment of space and purchase equipment (<$5,000)
- Transitioned existing LPNs from infusion to clinic
- Cross-trained clinic LPNs to central line care
- Phased approach: one clinic at a time
- Engaged scheduling staff and RN Care Coordinators

4 Chairs → 7 Chairs

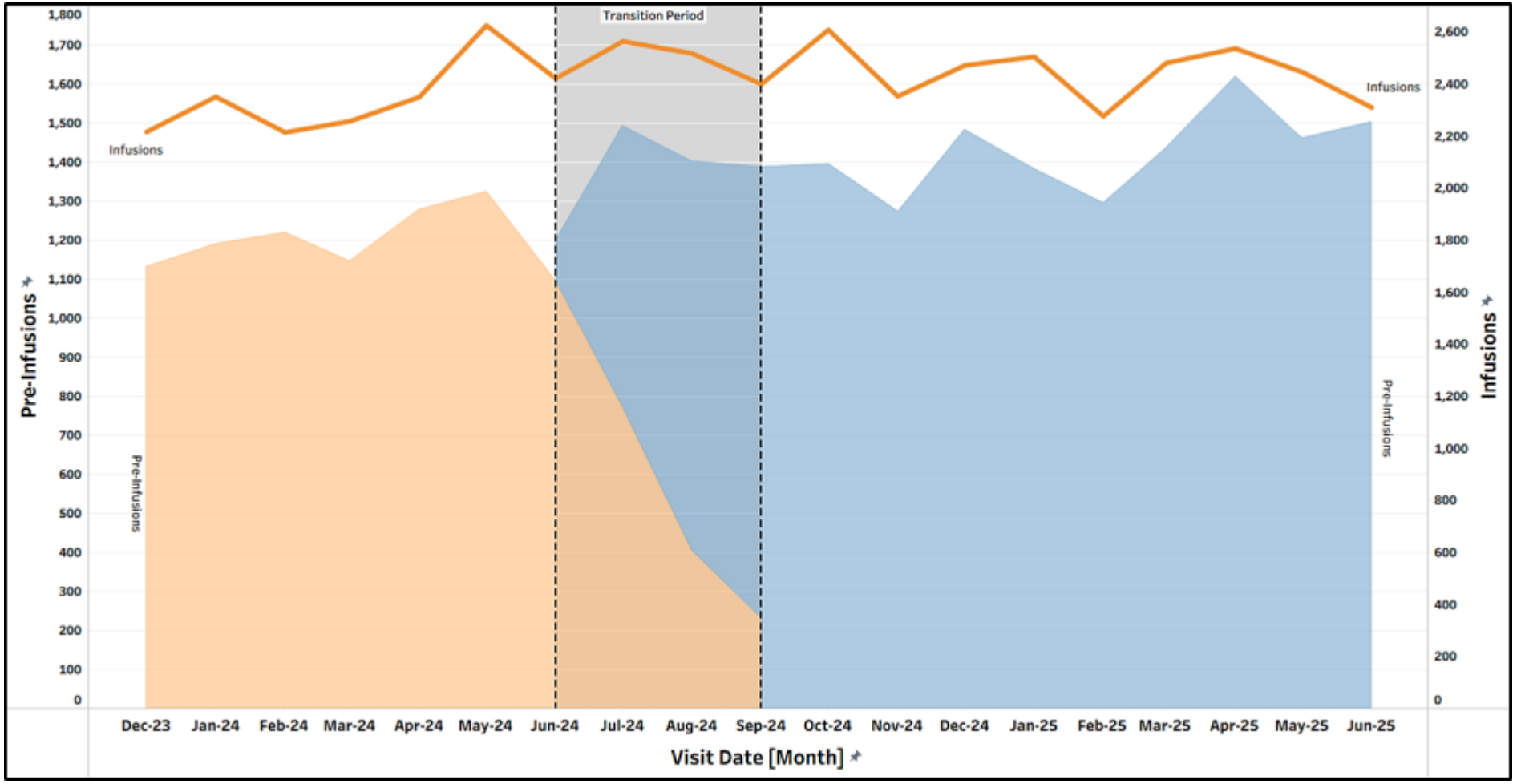
Implementation

- Lessons Learned:
  - Phased approach created staffing constraints
  - EHR department build needed to release certain orders
  - Training on US IV needed to prevent delays waiting for infusion resource
  - Win: created partnership with infusion/pre-infusion/inpatient CLABSI champions

Outcomes - Throughput



Outcomes - Capacity



Data source: UVA Health Oncology Service Line – Volumes from EMR

Outcomes – Patient Experience

- Before change: ~30% of patients with central lines had peripheral labs even when being accessed for treatment due to access barriers
- After change:
  - Reduction of need for peripheral labs
  - Reduction in wait times for labs

Lessons Learned

- Appreciate your interdependencies – looking at this as a collaboration rather than redirection of work was essential.
- Novice practitioners may struggle with new skills. Intentionally comingling the skill mix helped to jump-start confidence.
- Identify and trial the right resources (ex: our IV machine initially purchased ended up not being the staff choice).
- EHR mapping matters – we did not anticipate that some treatments wouldn't be viewable in some EHR contexts and had to rely on work-arounds temporarily.
- Using metrics such as chair occupancy and daily revenue helped quantify the value of the intervention and demonstrate return on investment.

Key Takeaways

- Assess low acuity services such as lab draws, IV starts, line flushes or simple injections. Consider what is necessary for an Infusion Chair with RN level care, vs. LPN/MA, etc.
- Consider your space – what space is underutilized, or could be optimized
  - Look at non-clinical space. What is essential, vs. what could be optimized (we repurposed an underutilized procedure room, and a closet that was used for “catch all” purposes)
- Collaboration is key – engaging frontline staff and leaders from all involved parties was essential to success
- Education and preparation – what existing education can be leveraged, versus what do you need to build

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Questions?

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