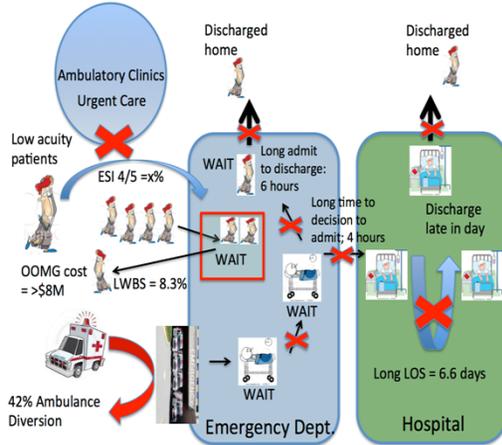


Title: Optimizing patient flow throughout SFGH

Owner/Date: Dentoni, Marks, May

I. Background: SFGH, historically has not paid much attention to flow of patients into, through, and out of the hospital. With increasing demand for services and the need to control costs as an ACO, SFGH has wrestled with the impact of broken patient flow for the last several years. SFGH has made several well-intentioned attempts to address barriers to flow in a sporadic, uncoordinated, and unsustainable manner. This has generally been unsuccessful, resulting in few measurable and sustainable improvements in patient flow.

II. Current Conditions: Patient flow within and between Departments is characterized by long wait times that impact our ability to provide timely access to care for patients. In the ED, SFGH is on ambulance diversion 42% of the time, patients leave the ED without being seen 8.3%¹ of the time and patients wait on average 225 minutes² before being admitted to the hospital. Contributing to the ED backup is the number of lower acuity (ESI 4/5) patients that could have been seen elsewhere in the SFHN (primary care or urgent care). Within the hospital, average lengths of stay are long (6.6 days)³, patients are discharged late in the day (3:05PM on average)⁴ and lower level of care patients (LLOC) not requiring hospitalization reduce available beds. The net impact is poor patient quality and satisfaction and a negative financial impact (OOMG annual costs of \$8M/yr). While providers and staff within a Dept see the effects of poor flow, they frequently attribute it to aspects that are not under their direct control (happening outside of their Department or not fixable).



Problem Statement: A lack of standardized flow processes within and between service lines results in long lead times, reduced quality of care and patient satisfaction, physician and staff frustration and a negative impact on our financial health.

III. Targets and Goals

1. Initiate a plan to improve ED and hospital flow based on A3 thinking, value stream mapping and a Lean management system by July 2015.
2. Decrease ED Diversion Rate from 42% to: 35%
3. Reduce ED patient LWBS/T Rate from 8.3% to: 6%
4. Reduce ED time to decision to admit from 225 min. to: 180 min
5. Reduce mean time from admit to discharge from the ED from 366 min. to: 300 min
6. Increase percent of patients with hosp. discharge by 12:00 PM from 16%⁴ to: 20%
7. Decrease average length of stay from 6.6 days to: 6 days
8. Reduce number of LLOC patients from x to: 12
9. Financial - Reduction in OOMG from \$8.0M to: \$6M

	1 Yr. Target	3 Yr. Goal
1. Initiate a plan to improve ED and hospital flow based on A3 thinking, value stream mapping and a Lean management system by July 2015.		
2. Decrease ED Diversion Rate from 42% to:	35%	0%
3. Reduce ED patient LWBS/T Rate from 8.3% to:	6%	2%
4. Reduce ED time to decision to admit from 225 min. to:	180 min	120 min
5. Reduce mean time from admit to discharge from the ED from 366 min. to:	300 min	180 min
6. Increase percent of patients with hosp. discharge by 12:00 PM from 16% ⁴ to:	20%	35%
7. Decrease average length of stay from 6.6 days to:	6 days	5 days
8. Reduce number of LLOC patients from x to:	12	6
9. Financial - Reduction in OOMG from \$8.0M to:	\$6M	\$4M

IV. Analysis

1. There are no agreed upon priorities, process or target metrics to improve ED and hospital flow.
2. There is no daily management system or local visual management boards to sustain gains.
3. Priorities between clinical care, research and education are not balanced resulting in lack of attention to broken clinical care paths.
4. There is little coordinated teamwork between physicians, nurses and ancillary staff
5. Provider productivity levels have not been defined and are not incentivized.
6. A 'hero mentality' exists in some areas which values certain work and effort at the expense of efficient flow within and between Departments.
7. The largest barrier to flow is within the ED; 80% of ED patients are discharged, only 20% admitted, followed by flow through the hospital; as such, these are the highest yield areas for improvement.
8. Lower acuity patients who could be seen elsewhere within the network contributes to the disruption of ED flow by increasing volume.
9. Absence of inpatient beds from long LOS, late discharges and LLOC patients contributes to the back up in the ED as well as backup of post-operative patients in the ICU and PACU.

Root Cause: There is no coordinated and integrated approach to managing flow based on careful analysis of the problem, root causes, and formulation of strategic, well organized countermeasures.

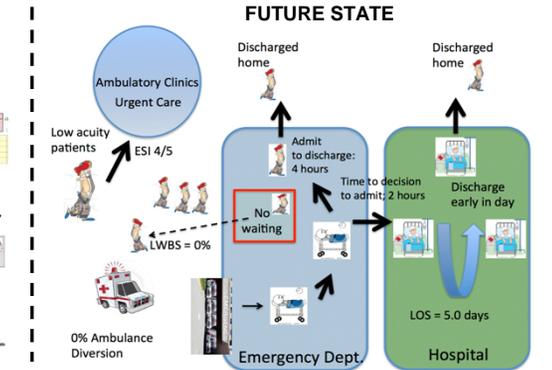
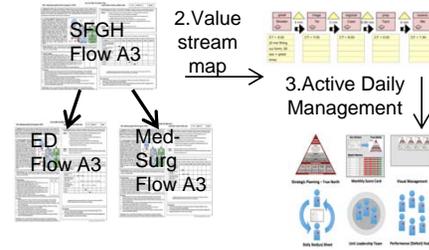
V. Countermeasures: Develop a coordinated, integrated and phased-in approach to manage flow based on developing our people to analyze the problem, define its root causes, and formulate strategic, well organized countermeasures.

- Phase 1:**
1. Determine SFGH Flow Target Metrics and Goals (This document)
 2. In the Emergency Department and Med-Surg Wards of the Hospital
 - a. Conduct an A3 Thinking Workshop for key ED and Med Surg leaders
 - b. Develop individual A3's for ED and Med-Surg that define the flow problem and countermeasures and prioritize their deployment
 - c. Use A3's as framework to value stream map ED and Med Surg flow
 - d. Initiate active daily management, unit scorecards, unit leadership teams and visual management boards in ED and Med-Surg.

- Phase 2:** 1. Spread above approach to Urgent Care starting Oct 2015
Phase 3: 1. Spread above approach to Ambulatory Clinics and post-hospital discharge resources (Respite, Housing, etc). Starting Nov 2015

VI. Plan: Initiate July 2015

Develop A3 thinkers using Lean methods and unit based A3's in problem solving.



Phase Activity/Timing	Jul	Aug	Sept	Oct	Nov	Dec	Jan 16
Phase 1* A3 Thinking Workshop: ED and Med-Surg leaders	←	→					
Individual A3's: ED & Med Surg:		←	→				
Value Stream Map ED & Med Surg and other Kaizen events			←	→			
Initiate ADM, unit scorecard, leadership teams, VMB's						←	→
Phase 2: Spread to Urgent Care					↔		
Phase 3: Spread to Amb. Clinics							↔

- Leadership teams at each tier level for Phase 1 will connect with Med Surg and OR Peri Op Model cell leadership teams for lessons learned exchanges. LMS Training and KW or VSM workshops will be coordinated and supported by KPO

VII. Follow-Up

1. Each of the major elements will complete and share a documented "reflections" at the conclusion of each element implementation.
2. The Theacare Monthly Scorecard Performance Review and communication strategy will be deployed as standard work in each of the 3 phases.